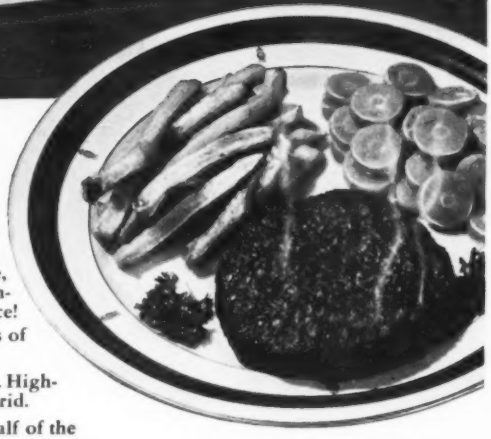
The Modern Hospital

OCTOBER 1952

Convention Digest (Page 51) • Administrators' Salaries • The Best Nurses Aren't Always the Best Executives • Two-Way Communications Systems • Blue Cross Costs • Licensing in Indiana • Meals in Small Hospitals • How to Buy Insurance

Increase Griddle Output up to 100%

Hotpoint Commercial Cooking



NEW DUO-GRID COUNTER GRIDDLE WITH TWIN THERMOSTATIC CONTROLS PRODUCES OVER 300 GIANT HAMBURGERS PER HOUR!

Can your present equipment match this production record? *Duo-Grid*, brilliant new addition to Hotpoint's Custom-Matched Counter Line, actually griddles as many as 300 huge 3-oz. hamburgers per hour in little more than 2 ft. of space!

Here are just a few of the outstanding features of this amazing new griddle—

NEW pre-heating speed—400° in a fast 10 minutes. High-powered electric heat is applied *directly* to the grid.

NEW twin thermostatic controls operate either half of the griddle separately . . . both halves at different temperatures . . . or the entire griddle at one uniform heat.

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And because of its even, automatically controlled electric heat, Duo-Grid gives *perfect* griddling, *always*, another triumph for the MODERN Hotpoint method.

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B.F.Goodrich

X-ray shows uniform strength of B. F. Goodrich surgeons' glove

THE X-ray above shows why B. F. Goodrich surgeons' gloves last so long and, of course, the more times a pair of surgeon's gloves can be used, the less they cost per operation.

The X-rayed glove was picked at random from regular stock. As you can see, there are no weak spots, no thin or heavy spots. From wrist to fingertips, B. F. Goodrich surgeons' gloves are *uniformly* strong—uniformly free of defects. It is impossible for foreign particles to get imbedded between layers because these gloves are made of just one single layer of purest latex.

Because of their uniform strength, B. F. Goodrich surgeons' gloves withstand frequent autoclavings and continue to give perfect service, operation after operation.

These gloves are available in a full range of accurate sizes in three types: surgeons' operating gloves, short wrist examining gloves and "Special Purpose" gloves for those who develop an allergic dermatitis when wearing ordinary rubber gloves.

Order B. F. Goodrich gloves from your surgical or hospital supply dealer. *The B. F. Goodrich Company, Sundries Division, Akron, Ohio.*

B.F.Goodrich
Surgeons' Gloves

The Modern Hospital

OCTOBER 1952

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AMONG THE AUTHORS


Dr. M. O'Malley

Dr. Martha O'Malley is director of the division of hospital and institutional services for the Indiana State Board of Health—the agency which has administered Public Law 725 and developed the hospital licensing program described in her article on page 81. A graduate of the State University of Iowa College of Medicine, Dr. O'Malley practiced pediatrics before entering the public health field, and is a diplomate of the American Board of Pediatrics. During her administration of the hospital program in Indiana, Dr. O'Malley has visited hospitals throughout the state, working with administrators, trustees and staff members in an effort to analyze professional problems. She has been active in hospital association work and has contributed several articles on these studies to The MODERN HOSPITAL.


Harlan J. Paine Jr.

Harlan L. Paine Jr. is administrator of Winchester Hospital, Winchester, Mass., a suburban institution that has recently been through the labor pains of expansion and modernization. A graduate of Northwestern University with a master's degree in hospital administration, Mr. Paine served his administrative residency at Massachusetts General Hospital, Boston, and served as an administrative assistant at Massachusetts General before moving to Winchester. He is a graduate of Brown University and was a member of the staff of Massachusetts Blue Cross before entering the hospital field. Mr. Paine's article on the community's obligations to its hospitals appears on page 89 of this magazine.


E. A. Johnson

Everett A. Johnson, whose article on nursing administration appears on page 68, is superintendent of Chicago Memorial Hospital. A graduate of Northwestern University, Mr. Johnson has his master's degree in hospital administration from the University of Chicago. Following completion of the university program, he served his administrative residency at Methodist Hospital, Gary, Ind. He returned to Chicago as superintendent of Chicago Memorial in July 1951.

Dr. Crawford N. Baganz is manager of the Veterans Administration Hospital at Lyons, N.J. Before he took on his administrative responsibilities, Dr. Baganz was professor of neuropsychiatry and head of the department at the University of Arkansas School of Medicine. He is a diplomate of the American Board of Neurology and Psychiatry, in which field he practiced for a number of years. He is president of the New Jersey Neuropsychiatric Association and clinical professor of psychiatry at New York Medical College. **Dr. Paul Weitz,** one of Dr. Baganz' co-authors (see page 79) is clinical director of the V.A. Hospital at Lyons and associate professor of psychiatry at New York Medical College. The third author, **J. M. Nichols,** is assistant manager of the hospital. He has served in executive positions in a number of V.A. hospitals during his 30 years of experience.


Dr. C. N. Baganz


Dr. Paul Weitz


J. M. Nichols

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Reader Opinion

Why Not Include Nurses?

Sirs:

Something is missing in the picture "The Eyes of Texas Are on Nursing" in the July issue of The MODERN HOSPITAL.

The problems involved in giving adequate nursing care to patients are certainly of vital importance to hospital administrators everywhere. The fact that a group of them gets together and "does something about them" is admirable. I wonder if any of these men ever actually gave a day of nursing care or even observed the details of such care. Nursing is only one of an administrator's many problems but the director of nursing service lives with it every day. Why not include at least one of your nursing leaders (and Texas has many of them) in any conference which has to do with training nursing personnel and looking for solutions to the many nursing problems?

If hospital administrators and nursing service directors got together more often and discussed mutual problems, each would profit from the rich experience of the other and it is possible that workable solutions might be found to many more of the difficult situations with which hospitals are faced.

Furthermore, since the nursing director must necessarily implement any plans which are made for her department, would it not make for better interpersonnel relations if she participated in making those plans?

Mary V. Cheek
Director of Nursing
The Queen's Hospital
Honolulu, T.H.

Tax Exemption

Sirs:

The article, "Hospital Loses Tax Exemption," in the August issue of The MODERN HOSPITAL should prove of extreme interest to all tax exempt hospitals in every state, as well as to those in California where the supreme court handed down its verdict.

It seems to me the important point in this decision is the part of the statement made by the court, "it is not necessarily whether there is or may be a profit but whether the claimant (hospital) is operated or conducted for the purpose of making a profit; that is, whether the charges are fixed with the intention of yielding a surplus over and above operating expenses."

It has always been my contention that a hospital incorporated not-for-profit has no moral right to use the income derived from patients for any purpose other than the cost of operating the hospital—the cost of the product the hospital is selling, namely, service. The cost of a hospital plant, *i.e.* the physical facilities, should be wholly provided by the generosity of the entire community. The burden of financing hospital care is sufficiently

heavy without inflating charges for services to the figure that will retire the bonded indebtedness, thereby placing the cost of hospital care *and* the cost of physical facilities only on those who find it necessary to use such facilities.

I would not argue for or against a reasonable amount of depreciation of equipment used for the purpose of rendering direct patient care without studying the matter very carefully.

There are a number of executives who have opposed my thinking on this whole subject. Maybe they are right and I am wrong. In all the discussions I have participated in, I have yet to hear one logical reason given to support their views.

Now we have a decision of the supreme court of the state of California that coincides with my contention of long standing.

In view of the uncontrollable and natural causes that have skyrocketed the operating cost of hospitals and made it necessary for them to increase all service charges the increased feeling of the general public regarding present charges, and the desire of hospitals in general to maintain the friendliest possible hospital-public relationship, it would appear timely for the American Hospital Association to issue a statement of policy to its membership clearly defining what constitutes the operation of a nonprofit hospital.

Those of us who have been associated with administration of hospitals for a number of years can see the "handwriting on the wall" as regards the courts becoming less and less liberal in decisions concerning nonprofit hospitals. Supreme courts in many states have ruled against defendant hospitals in matters of malpractice and patient and public liability—a reversal of the one-time belief that a judgment should not be rendered against a nonprofit hospital because the satisfaction of such a judgment would be using hospital funds contrary to the purpose for which the hospital operated, thus frittering away funds that should be used for other purposes. We have observed real estate taxes assessed and collected on hospital property that was not being used for hospital purposes, although all the income from such property was used to support the operation of the hospital, even though the hospital had, since acquisition of the property, enjoyed it tax free. Now we have the ruling of the supreme court of the state of California that the hospital itself must pay taxes.

It would be foolish indeed to ask if such a ruling will improve hospital-public relationship, a ruling that says ". . . plaintiff [hospital] functioned on a sound financial basis in a manner akin to any modern commercial enterprise intent upon producing a profit from its operation." If the statement had merely said that the hospital operated on a sound financial basis there would be little reason for criticism, but it went further to recite amounts and percentage of earnings to compare with commercial ventures.

I regret that I must disagree with the views expressed by my good friend E. E. Salisbury. I would not accept a defensive stand in the matter. In spite of what it may mean, I believe the court rendered a fair decision.

It should result in a lesson to all of us to make some adjustment in our practices and train our sights to conditions under which we will eventually have to operate.

J. Dewey Lutes
Superintendent
Woonsocket Hospital
Woonsocket, R. I.

LOWEST *X-Ray Costs* FOR ADMISSIONS

Westinghouse Stationary PF Unit

For routine chest X-rays in the small hospital, clinic, or industrial plant, the Westinghouse Stationary PF Unit and 70 mm Cut-Film Camera offer the lowest over-all cost of any system available.

Look at these advantages:

- **Lowest initial cost for equipment.**
- **Use with present equipment.**
- **No special darkroom equipment required.**

In addition, the Westinghouse Stationary PF Unit offers these operational features:

- **Immediate development and study of film.**
- **No change in existing filing system required.**
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MEDICAL X-RAY

J-08273

Roving Reporter

Twelve Can Ride

In a large city like New York an ambulance call may be for a 7 pound infant or for a dozen persons. Viewing present needs and keeping one eye cocked on civil defense preparations, the Department of Hospitals of New York has put on the streets 22 ambulances of a new type; more are on order.

In 1951 the city ambulances of New York carried 380,000 persons in 377,000 trips. Such mileage creates a big problem of maintenance. The standard vehicle used in New York for the last 10 years was a heavy pleasure car chassis; on this type of ambulance a new front end was needed every six months. Engines for these large cars are expensive replacements.

The first of the new type of ambulance was put on the street by the Department of Hospitals in May 1951 and within the first nine months ran up 22,000 miles of city driving without any major overhauling being required.

The new ambulances are built on a truck chassis to which has been added airplane shock absorbers and springs. They have a 134 inch wheelbase in contrast to the 163 inch wheelbase of the older chassis, and this makes driving easier and permits greater maneuverability in crowded city areas. One of the new ambulances will ride 12 ambulatory patients or four stretcher patients or six ambulatory plus two stretcher patients. The interior design is such that the hanging stretchers disappear into the roof.

One adaptation of the new type of ambulance is the premature transport ambulance, a part of a program operated jointly by the department of hospitals and the health department. Designed to maintain controlled temperatures, the ambulance consists of a two-compartment stainless steel incubator with a thermostatic heating system.

Collector's Item

A species of the genus Post Card Collector is the collector of hospital post cards. Members of this species are hardy fellows, not too esthetically inclined. A common type of hospital post card depicts a red brick rectangular box sitting on a vivid green lawn against a background of royal blue sky. In the foreground sometimes appear a bed of shocking pink geraniums and several high slung automobiles nudging a retouched and unblemished gray curbing.

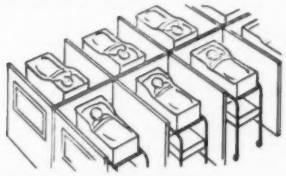
Subtlety, thou art a jewel! A jewel of a hospital post card is one that patients can send from Lakeside Memorial Hospital, Brockport, N.Y., where May H. Epke is administrator. It's an attractive new one-story hospital and the architect's pencil sketch of the building has been printed on an oyster white, matt finish card. The sketch is charming in its restraint except that a little artistic license has been taken with the landscaping, for the trees are of taller grace and the shrubs of sweeter contours than

New 2-Way BASSINET

1. FOR ROOMING-IN TECHNIQUE
   or
2. FOR CUBICLE ARRANGEMENT IN NURSERY

ROOMING-IN TECHNIQUE

The bassinet is wheeled from the nursery to the mother's room. The entire unit is light in weight and moves easily on rubber-tired swivel casters. Extra-long extension base slides under bed, brings basket and supplies within easy reach for mother to work on infant.



CUBICLE TECHNIQUE IN NURSERY

Self-contained bassinet holds all necessary equipment for individual attention. Basket, utensil holder and shelf are conveniently accessible. Light weight and simplicity of design aid flexibility of arrangement. Unit takes up minimum amount of space, gives nurse ample working area.

REMOVABLE PLASTIC BASKET — Light weight and sanitary. All corners and edges are rounded. Basket can be tilted at either end. Has name-card holder.

UTENSIL HOLDER is portable and can be attached to either side of stand within easy reach of mother or nurse. Metal containers hold cotton balls, oils, swabs, and other supplies.

SHIELDED SHELF holds linens, diapers, blankets, etc. Welded to stainless steel tubular uprights. Inside corners rounded to facilitate cleaning.

EXTRA-LONG EXTENSION BASE — designed to slide under bed. Brings basket and accessories within easy reach for mother to work on infant.

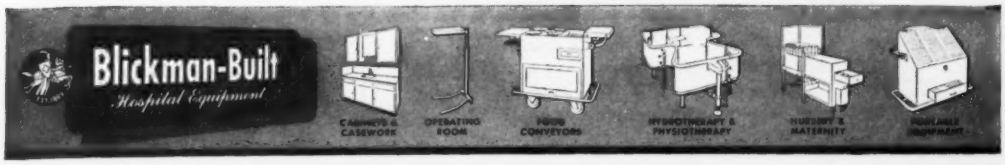
BOYLSTON Model STAINLESS STEEL BASSINET with Plastic Basket

• Whether your institution employs rooming-in technique or cubicle nursery arrangement, this low-cost stainless steel bassinet serves either with utmost safety and facility. All necessary supplies are within convenient reach of nurse or mother. Simple in design, of sturdy, welded construction, the bassinet is easily cleaned and sterilized. There are no painted surfaces to chip or crack, no dirt-collecting joints or crevices. Here is a Blickman-Built unit priced to meet your budgetary requirements — yet so durable that it virtually eliminates maintenance or repair costs. Write for further information.

SEND FOR OUR CATALOG 11-NEC

• Illustrates and describes many other units of Blickman-Built equipment for nursery and pediatric departments, as well as for milk formula rooms.

S. Blickman, Inc., 1510 Gregory Avenue, Weehawken, N. J. New England Branch: 845 Park Sq. Bldg., Boston 16, Mass.



actually exist at present. The name of the hospital appears in modest capitals at the top. There's a post card, collectors, that's worthy of a place in your hospital album.

Iowa Offers Warm Welcome

The experience of traveling to another town or across a state to enter an enormous hospital can be terrifying. The State University of Iowa Hospitals appreciates the nervous apprehension of those children and adults who ride the big blue ambulances across the Iowa prairies to the state hospital plant that crowns a river bluff at Iowa City.

For more than a year now, some of the tension of this ambulance journey has been relieved by a little pamphlet the patient receives before he leaves home. This booklet is as friendly in tone as a next door neighbor, and the simple story of what lies ahead in the hospital is told with warmth and, actually, a certain charm.

By the time the ambulance pulls up to the group of 10 hospital buildings the patient knows a great deal about what lies ahead of him. He knows about the hospital's 11 clinics for outpatients and where outside the hospital he can be housed and where he can get his meals. And if he is an inpatient he has learned most of the ropes before he has set foot inside the door.

A booklet like "It's Your Hospital" is hard to write; to maintain the human warmth of its tone takes skill and love of humanity. That effect has been achieved, and Supt. Gerhard Hartman and his staff must have sensed the difference it makes from the very beginning of its distribution.

Mane of Horse, Hair of Hog

There are no statistics on how many hospitals make their own mattresses. In fact it was news to your Roving Reporter that any hospital undertakes such a project. However, Hartford Hospital, Hartford, Conn., is full of surprises.

This hospital's upholstery shop had been making innerspring mattresses for some time and it took Frank Healy, head upholsterer, and his assistant 11 hours to complete one. Now filling a mattress cover takes only 6½ hours, because the women's auxiliary forked over $695 for an automatic mattress filler.

Looking somewhat like an oversized, unpolished upright piano, this piece of equipment at the flick of a switch stuffs a mattress cover with layers of cotton and hair, burlap and springs. The open end of the cover is then stitched shut by a "closer" sewing machine and the mattress is then tufted to keep the filling from shifting around.

Hartford Hospital uses 11 pounds of cotton and 11 pounds of hair for each mattress for an adult sized bed. The hair is a combination of either horse's mane and gray hog hair or cattle tail and hog hair, as these combinations have been found to produce the greatest resiliency. The upholstery shop at the Hartford Hospital has two closets filled with bundles of hair and rolls of cotton, protected by a ceiling sprinkler system.

How safe is your hospital?

International News Photo

Above: Fire in a mid-western hospital, out of control, destroys the building, takes the lives of forty patients.

This year there will be an average of three hospital fires reported per day and they will follow the general pattern shown in the insert.

Not all of these fires will develop into disasters, for most modern hospitals have excellent fire protection. But experience shows that some few will, and that these few will take an almost inevitable toll of lives and property. These will be hospitals not now provided with means of stopping fire *quickly at its source.*

Hospital fires *must* be put out before choking fumes reach bedridden patients, before searing heat can seal off floors or corridors, before panic can have a chance to develop. Grinnell Automatic Sprinklers offer such protection. Grinnell Automatic Sprinkler Systems guard against loss of life and property by stopping fire at its source, wherever and whenever it may strike, with automatic certainty. Seventy-four years experience proves this.

For help in planning fire protection, without obligation to you, write Grinnell Company, Inc., Providence, R. I. Branch offices in principal cities.

Here's Where Hospital Fires Start

(Survey by National Fire Protection Association)

Service Rooms **52.1%**

Outside **15.5%**

Patients' Quarters **11.4%**

Nurses' Rooms **5.8%**

Operating **3.3%**

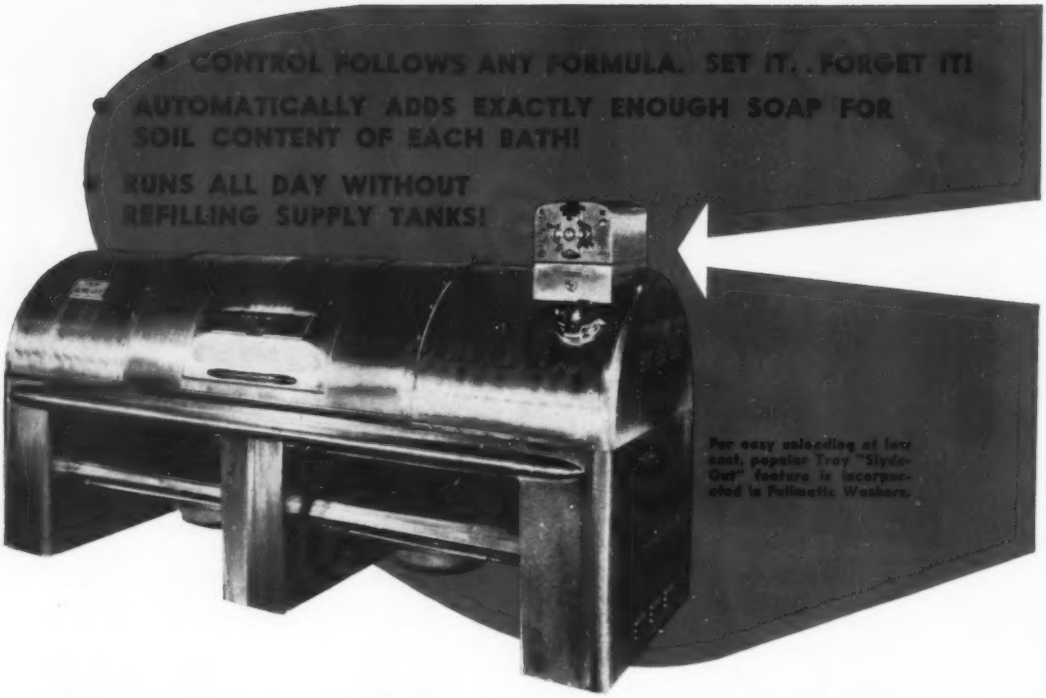
Miscellaneous **11.9%**

GRINNELL
FIRE PROTECTION SYSTEMS

Manufacturing, Engineering and Installation of Automatic Sprinklers Since 1878

IT'S HERE . . . THE FIRST

New! TROY

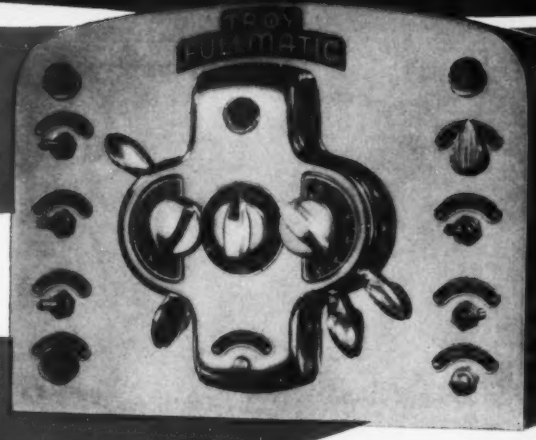


Now Troy proudly presents *the first truly automatic washer.* The Fullmatic Control follows any formula you select. Just set it and forget it. This control automatically regulates water temperature and fills cylinder to correct level for each washing operation . . . automatically injects exact amount of soap required for soil content of each load . . . adds measured amounts of other supplies when needed . . . regulates the number and length of suds and rinse operations . . . times each operation exactly, then drains machine . . . starts new operation . . . indicates washing progress by pilot lights . . . flashes 'finish' light and rings bell at close of washing cycle.

This new Troy Fullmatic is the result of 10 years of field research, engineering development and laboratory testing. In addition, selected laundries in different geographic locations have operated Troy Fullmatic Washers daily under actual

TRULY AUTOMATIC WASHER

FULLMATIC *Washer*



"We have two Fullmatics . . . We are waiting anxiously for three more Fullmatics we have on order because we know we will be able to eliminate one man as soon as they arrive."
— Wilbur S. Kelley, Jr.
Vice President
Kelley Laundry and Dry Cleaners
San Diego, California

plant conditions. Charles N. Brock, owner of Getchell Laundry and Drycleaning Company, St. Joseph, Missouri, says: *"We installed a Troy Fullmatic Washer at Thanksgiving time in 1950. Every day, I am more and more convinced that it is the best washer of its kind on the market, and one of the best investments we ever made."*

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WORLD'S LARGEST BUILDERS OF WOMEN'S LAUNDRY EQUIPMENT

"...as important as the surgery section – and we almost left it out!"

THESE board members have just reversed an earlier decision—made without adequate information—and have decided to include individual room temperature control in the new hospital they're building!

As one board member put it:

To economize, we decided to leave out individual room temperature control—even though we felt our new hospital would be old-fashioned without it. Then we learned the cost would only run between ½ and 1% of our total expenditure! You can bet we reversed our decision in a hurry!

The fact is, in many hospitals it's already routine medical practice to give each patient the exact room temperature he needs to speed convalescence. And *no other system* can compensate for the varying effects of wind, sun, open windows and variations of internal load.

Therefore, it's just good business to install individual room temperature control *when your hospital is being built.* Doing it later, as a modernization project, is sure to cost substantially more money.

For complete facts on Honeywell controls for your hospital, call your local Honeywell office—there are 96 of them located in key cities. Or write Honeywell, Dept. MH-10-218, 351 E. Ohio Street, Chicago 11, Illinois.

Only thermostat specially designed for hospitals!

No other thermostat offers hospitals all these features:

- ***"Nite-Glowing dials"*** permit inspection without disturbing patients.
- ***Magnified numerals*** make readings easy to see.
- ***New Speed-Set control*** knob is camouflaged against tampering.
- ***Air-Operated;*** requires no electrical connections.
- ***Lint-Seal*** insures trouble-free and dependable operation.

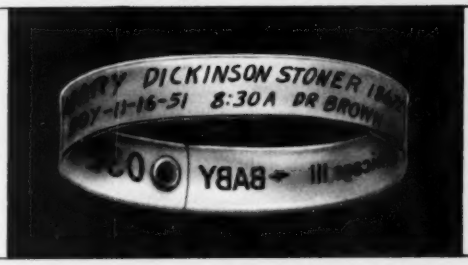
MINNEAPOLIS **Honeywell**

First in Controls

for Mother

Announcing a New Development in Mother-Baby Identification

The vital facts are sealed inside.



for Baby

Hollister® Ident-A-Bands

PATENT APPLIED FOR

Here's modern thinking applied to mother-baby identification. Matching transparent plastic bands . . . one for mother . . . one *(or two)* for baby . . . all prenumbered inside the band and ***sealed*** in the delivery room at time of birth.

The seal is an aluminum eyelet . . . closed in mere seconds with a simple hand instrument. Once sealed the band cannot be removed unless cut off, or obviously torn off with great force.

Baby's band shows baby's identification number, mother's name, baby's sex and birth date, doctor, and hospital number if desired . . . all instantly visible and *sealed* in a tiny band that fits neatly around baby's wrist or ankle.

Mother's matching band is just as trim and neat as baby's. Sealed inside the band are her baby's identification number and your hospital's name and a card. The band fits gently around her wrist and, like baby's band, it is not affected by water, oil or alcohol.

Write for a sample HOLLISTER *Ident-A-Band®* and additional detailed information. They will be sent to you by return mail without cost or obligation.

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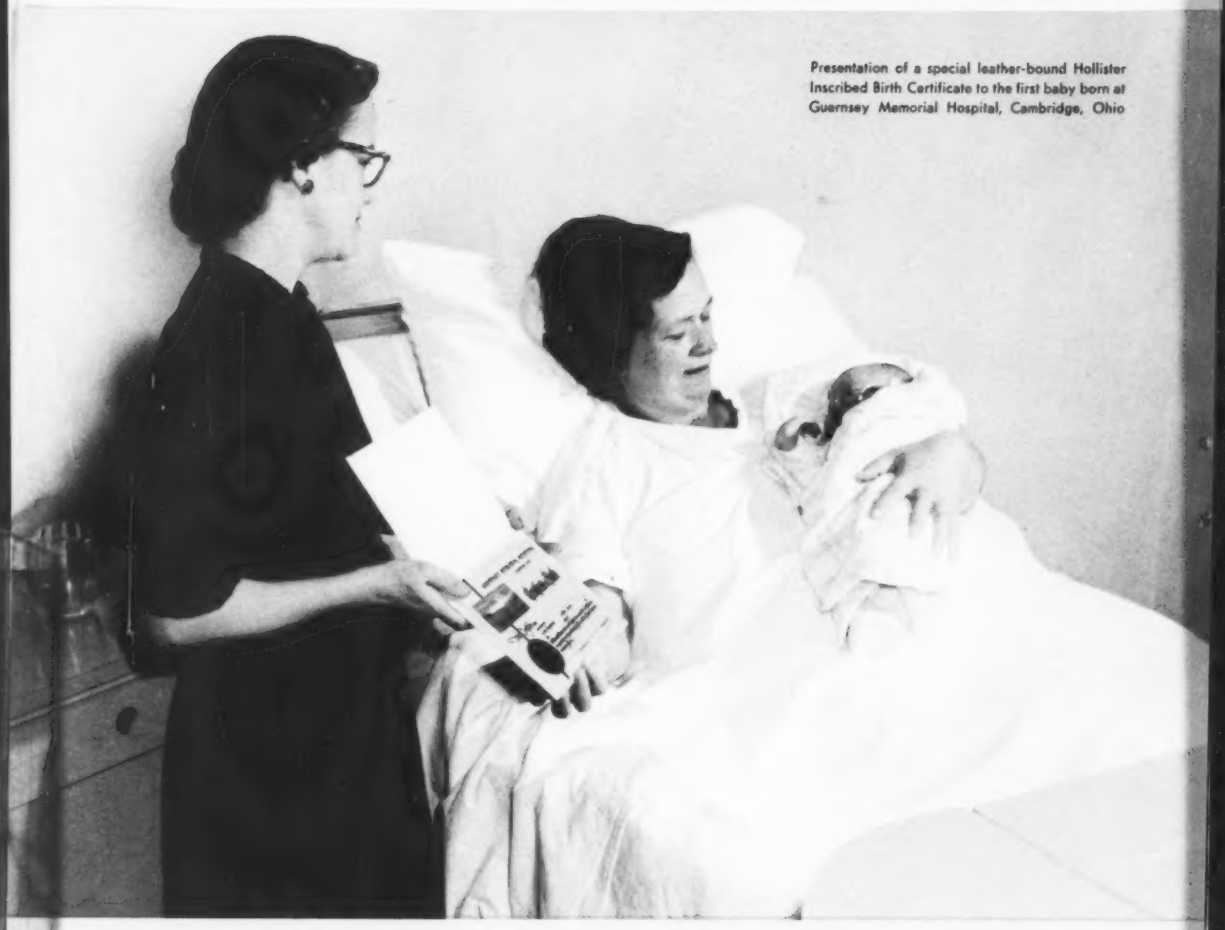


Presentation of a special leather-bound Hollister Inscribed Birth Certificate to the first baby born at Guernsey Memorial Hospital, Cambridge, Ohio

A Special Tribute – to a Very Special Baby

Little Gila Kay Blackstone, 8 lbs. 9½ oz., is a very special baby. Born 4:30 A.M. May 6, 1952, she is the first baby delivered in the new Guernsey Memorial Hospital, Cambridge, Ohio.

To honor the occasion, Guernsey Memorial presented the parents of Gila Kay with a Hollister *Inscribed* Birth Certificate in a fine leather folder.

Actually the birth of *every* baby is a special occasion . . . both to the parents and the hospital whose privilege it is to deliver the child.

That's why Guernsey Memorial will continue to honor the parents of every child born in their hospital with the gift of a Hollister *Inscribed* Birth Certificate.

They feel, as you will, this beautiful certificate expresses something of the joy and dignity of the occasion.

Send for your free copy of the 1952 Birth Certificate portfolio and select the style you want for your hospital.

FRANKLIN C. HOLLISTER CO. – 843 N. ORLEANS ST., CHICAGO 10, ILLINOIS

NAME _____

HOSPITAL _____

CITY _____

INDEX TO ADVERTISEMENTS

(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—29th Edition

Hospital Directors rejoice . . .

AT THE SAVINGS THEY MAKE in air conditioning and ventilating costs with Dorex Air Recovery. It's the most effective, most economical way of *maintaining fresh air* throughout your hospital.

When you make Dorex Air Recovery part of your air conditioning or ventilating system, you'll remove *at least* 95% of all adsorbable vaporous and odorous impurities—including such as arise from infections, medications, respiratory anesthetics and the like. And it's completely safe for use in conjunction with operating rooms.

In addition, you'll reduce the cost of installing and operating your system. With Dorex Air Recovery only about one-third as much fresh air need be taken in—the rest is recovered and re-used. Records of thousands of installations over the past twenty years show that every $100 invested in Dorex Air Recovery should save $400 on original equipment; and every $1 spent for Dorex maintenance should return a $4 saving in operating costs.

To find out exactly how Dorex Air Recovery can benefit your hospital, just mail the coupon today.

W. B. Connor Engineering Corporation, Danbury, Connecticut.

W. B. CONNOR ENGINEERING CORPORATION

dorex®
air recovery

W. B. CONNOR ENGINEERING CORP.
Dept. M-102, Danbury, Connecticut

Please send me, without obligation, full information on the use of Dorex Air Recovery in hospitals.

Name .....

Hospital .....

Address .....


The only Underpads with a
GREATER STRENGTH
QUICKER PENETRATION
Surgine Linen Savers
New low cost
disposable underpads
MASSLINN® non-woven fabric covering (not paper) holds together in use . . . quicker patient clean-up saves nurses' time.
Tissue filler of great absorptive capacity.
Folded, non-cutting edges.
Water-repellent backing.
Also covered with non-woven fabric:
The original TRI-PAD® Underpad—
for heavy drainage cases and incontinent patients.
HOSPITAL DIVISION

Covering of Non-Woven Fabric (NOT PAPER)

. . . wet or dry

. . . immediate absorption of drainage

Chux* Disposable Diapers

New . . . improved . . .

MASSLINN non-woven fabric covering*

Great tensile strength—wet or dry.

Soft and comfortable.

Ideal for many hospital uses.

Small size—9" x 14"

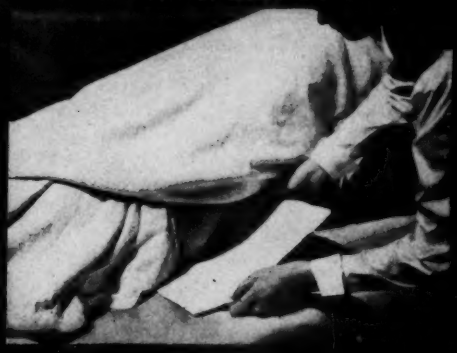
Large size—13" x 17½".

*Trade mark of Johnson & Johnson or its subsidiary

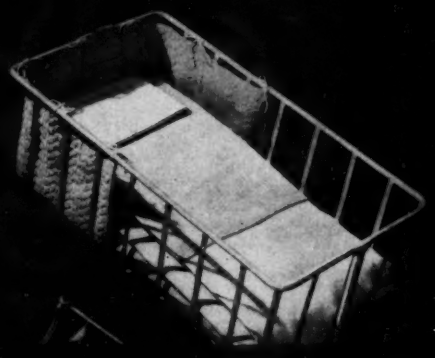
Johnson & Johnson

NEW BRUNSWICK, N. J. CHICAGO, ILL.

USES AS UNDERPAD

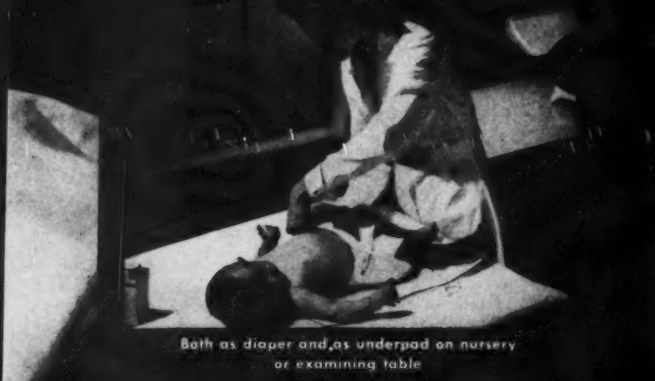


In maternity cases—to protect bed linen



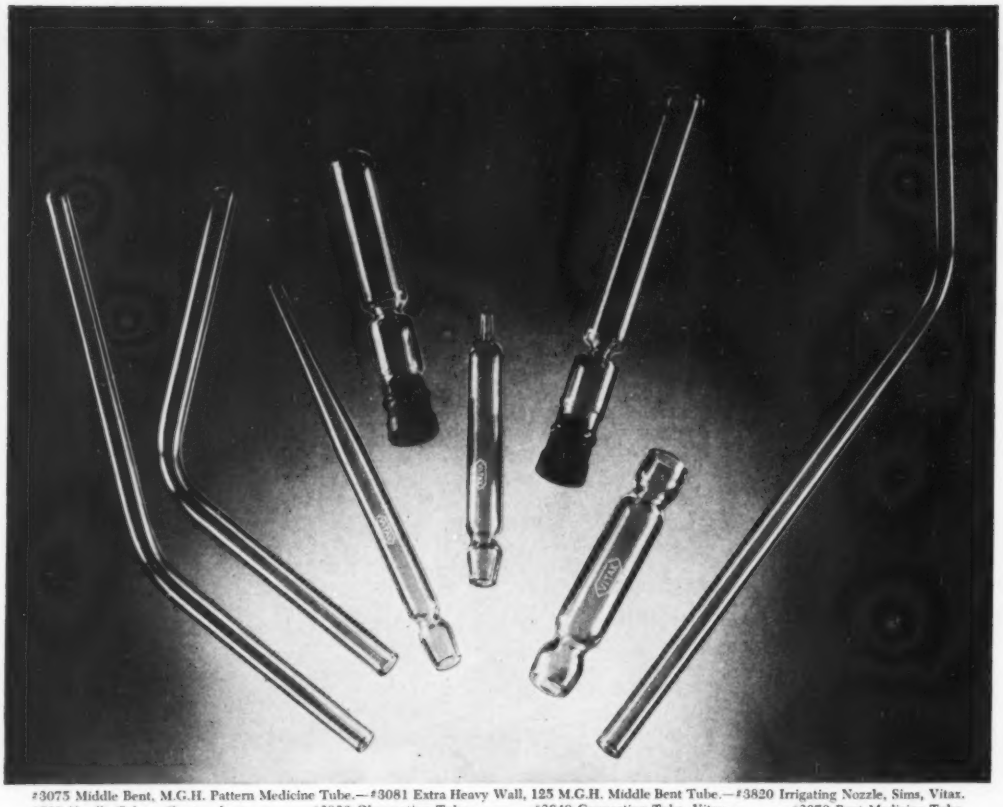
In bassinet—large size as underpad, small size as pillow

USE AS DIAPER



Both as diaper and as underpad on nursery or examining table

On the weighing scale



#3075 Middle Bent, M.G.H. Pattern Medicine Tube.—#3081 Extra Heavy Wall, 125 M.G.H. Middle Bent Tube.—#3820 Irrigating Nozzle, Sims, Vitax.
#500 Needle Tubes—Short or long.———#3920 Observation Tube.———#3640 Connecting Tube, Vitax.———#3070 Bent Medicine Tube.

WHY GLASCO GLASSWARE IS SO POPULAR WITH HOSPITALS

You can count on Glasco hospital glassware to give your hospital operation dependable, functional service

Glasco has a modern, functional design that is tailored expressly for hospital use. The tubes which you see pictured above are typical examples of this functional design. Made of a special-type, non-corrosive glass, Glasco glassware is commercially free from alkalis, and can be sterilized repeatedly without discoloring or clouding.

Glasco glassware is carefully annealed, too. Every piece of Glasco glassware is carefully retempered and reannealed to reduce strains and to increase strength and flexibility. That explains why Glasco tubes can withstand sterilizing and rough handling . . . why Glasco glassware is tough enough to give users dependable, year-in, year-out service.

Years of successful use by most of the country's leading hospitals confirm the outstanding performance of Glasco. Decide now to give your hospital functional and economical glassware service. Order Glasco hospital glassware from your hospital supply house, or write to us direct for a free copy of our latest catalog and price listing.

GLASCO PRODUCTS CO.

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS

only Bolta *gives you*

COLOR-and-PATTERN HARMONY in LAMINATED TRAYS

Also Famous Boltalite Hard Rubber Trays in Sizes 10x14, 12x16, 14x18 and 15x20. Also Boltabilt Trays in Round, Oblong and Oval Shapes, in 15 different Sizes.

BOLTA plays fairy godmother to your restaurant and gives it a lift, a sparkle, a bright new personality . . . with the witchery of color! For only BOLTA COLOR TRAYS are available in 36 magic combinations of modern color and texture, yes, 36 in all—to give your restaurant that *decorator* touch . . . at the amazingly low cost of only a few cents more per tray. And you *save* in the long run, because Laminated BOLTA Trays give you years of extra wear!

- In sizes 12x16, 14x18 and 15x20
- Non-porous, Satin-smooth Surfaces
- Impervious to Cigarette Burns, Food Acids, Alcohol, Fruit Juices
- Lightweight, Noiseless, Easy to Handle
- Washable in Mechanical Dishwashers
- Will not Break, Warp, Fade, Spot or Split

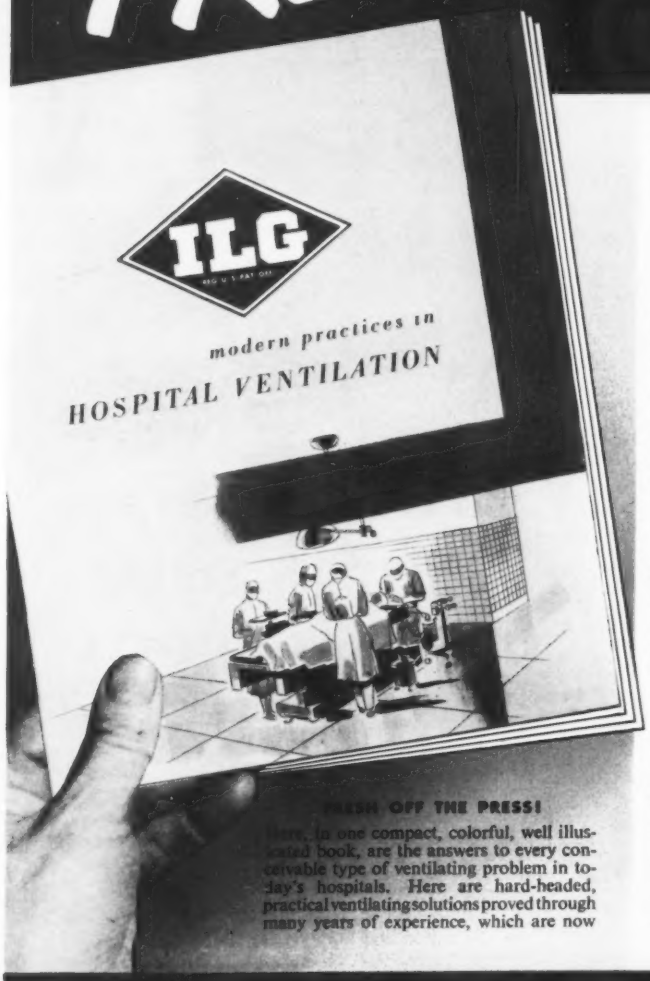
COLOR adds *business*... BOLTA adds *color*

Only BOLTA has perfected the techniques that make possible this combination of laminated patterned color and outstanding durability.

The **BOLTA** *Company*
LAWRENCE
MASSACHUSETTS

Planning to Re-decorate? Specify BOLTAFLEX *and* BOLTA-QUILT *for furniture and paneling*

FREE! ... ILG'S new practices in



FRESH OFF THE PRESS!

Here, in one compact, colorful, well illustrated book, are the answers to every conceivable type of ventilating problem in today's hospitals. Here are hard-headed, practical ventilating solutions proved through many years of experience, which are now bringing new comfort and new efficiency to various departments in hospitals throughout the nation.

BASED UPON NEARLY 50 YEARS OF EXPERIENCE

Luckily for you, the Ilg Electric Ventilating Co. has been a specialist in the ventilating and heating business since 1906. During these exciting 46 years, we have been called in to help engineer air moving systems for hospitals throughout the world. The best examples of effective hospital ventilation have been selected for illustration and description in this new authoritative guide. And this complete reservoir of data on specialized hospital ventilation is yours, without charge, when you mail the coupon on the next page.

PROVIDES SOLUTIONS FOR EVERY ROOM IN THE HOSPITAL

This new ILG "Guide" recognizes that each hospital is a small "city" with each department requiring individual ventilating treatment. Best solutions for ventilating each room, each department, each floor are offered you—solutions operating successfully in large and small, old and new hospitals.

ILG'S DISTRIBUTION NETWORK IS READY TO SERVE YOU

In over 50 of the nation's principal cities there are ILG Branch Offices, staffed with competent ventilating and heating engineers, ready and willing to work with you. Moreover, ILG equipment is stocked throughout the country by leading distributors, jobbers, and dealers, simplifying delivery problems. For prompt action, either call your nearby Branch Office (consult classified directory) or send coupon.

ILG
REG. U. S. PAT. OFF.

Self-Cooled Motor Propeller Fans • Direct-Drive Centrifugal Fans • Circulating Fans • Unit Heaters

Cheeseburger and cheese sandwich when you use KRAFT RIBBON

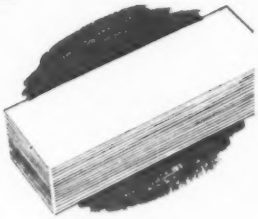
Ribbon Slices give you perfect portion control . . . save valuable time and labor costs

Kraft Ribbon Slices are like nothing else that has ever appeared on the market. They are not mechanically sliced process cheese . . . *they are made in slices* by a remarkable Kraft invention. And because their surfaces are not roughed up by a knife, they do not crack when you take a slice off the stack. They lift off "just like peeling a banana." With Ribbon Slices you get no broken pieces, no slivers, no dried out edges.

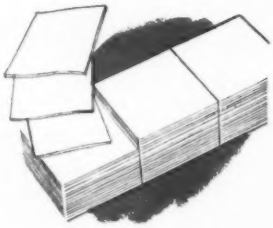
Kraft Ribbon Slices cut down your operating expenses by saving time and labor. The few simple cuts illustrated here give you perfect sandwich or cheeseburger slices in seconds . . . there's never any waste . . . that's perfect portion control.

Each sandwich-size slice is the same—exactly the same thickness, width and weight so you never have the problem of profit loss or customer complaint. Ribbon Slices mean accurate portion control in your cooked dishes, too.

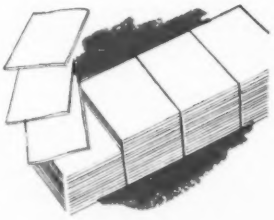
Kraft Ribbon Slices have an even better flavor than regular pasteurized process cheese because the new Kraft method actually enhances the flavor.



The convenient package of Kraft Ribbon Slices contains an oblong stack of sixteen 10½-inch slices. By simply cutting on the lines marked on the package you get accurate portion control.



Use the blue dotted lines on the package to cut 48 perfect sandwich slices . . . each exactly the same size and thickness, each weighing exactly one ounce. The operation takes only two cuts with a knife, only two seconds of your employee's time.



Use the red dotted lines on the package of Ribbon Slices to cut 64 perfect cheeseburger slices. With only three cuts you can get cheeseburger slices that weigh exactly ¾ of an ounce. They melt perfectly without running over onto the grill.

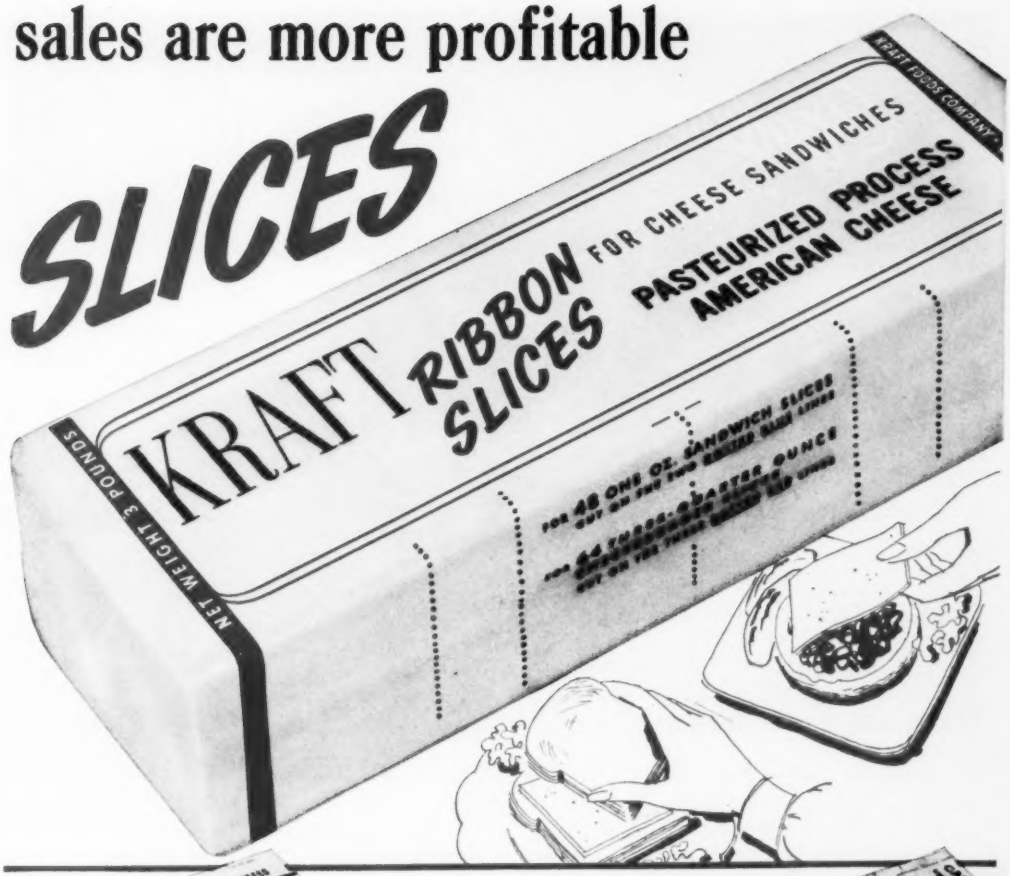
TRY KRAFT RIBBON SLICES

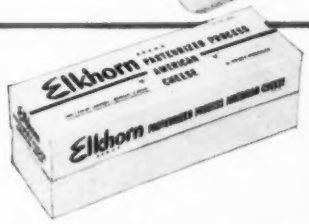
- ***Measured profit and greater convenience!***
- ***Cut down costly labor time!***
- ***Eliminate guesswork, loss and waste!***
- ***Cheese flavor your customers will like better!***

KRAFT
Foods Company
INSTITUTIONAL DIVISION

The Nation's Taste is your best Buying Guide

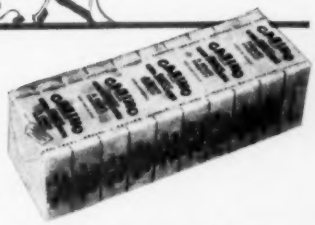
sales are more profitable





HERE'S THE PERFECT PROCESS CHEESE FOR COOKING! For all of your cooked dishes, you'll like the just-right, medium-mellow cheddar flavor of Kraft American pasteurized process cheese. It has long been America's favorite! Kraft packages this famous cheese under the name *Elkhorn Brand*, in 5-lb. loaves especially for the hotel, restaurant trade.

OLD-TIME TASTING CHEDDAR IN A CONVENIENT FORM—Kay Brand is delicious, natural cheddar at its best. Its mild flavor and top quality are always *uniform*... its shape more convenient. Kay Brand comes in a 10-pound bar with no rind, no waste, no paraffin wrapping. Easier to cut and slice . . . takes up less storage space in your refrigerator.

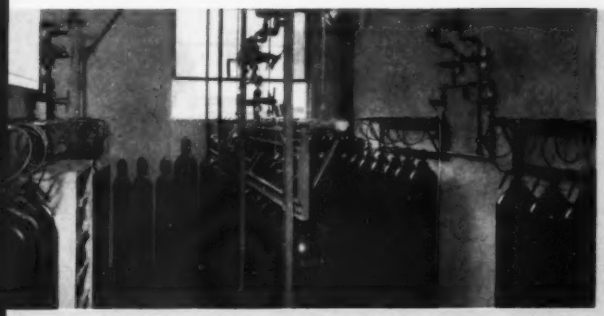


THE PERFECT SANDWICH CUT OF SWISS . . . NO RIND, NO WASTE—For "heart-of-the-cheese-goodness" Casino Brand is your best buy. Every piece of Casino Brand has the goodness you'd expect in a premium-price cut from the center of a huge Swiss wheel. Every cut is a squared cut! You can buy this time-saving Swiss in 10-pound cuts and 40-pound blocks.

Distributed direct and through service-minded jobbers everywhere BULK AND PORTION NATURAL CHEESES (imported and domestic) PASTEURIZED PROCESS CHEESES • CREAM CHEESES • GRATED CHEESES • KRAFT KITCHEN FRESH MAYONNAISE MIRACLE WHIP SALAD DRESSING • KRAFT FRENCH AND MIRACLE FRENCH DRESSINGS • CUISINE SALAD DRESSING SEA ISLAND DRESSING • MUSTARDS • HORSERADISH • SALAD OIL • PARKAY MARGARINE • MALTED MILK

picture story of NCG oxygen piping equipment at beautiful St. Johns hospital in Santa Monica

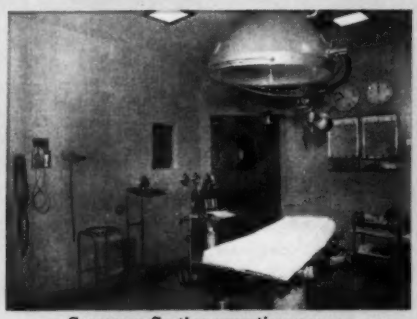
In beautiful Santa Monica, on the shores of sunny California, St. John's Hospital is completing a handsome new right wing, enlarging its capacity to 250 beds and 79 bassinettes. Among its many modern facilities is an extensive oxygen piping system using NCG equipment. Shown below are typical areas served by this convenient, safe and dependable form of oxygen supply.



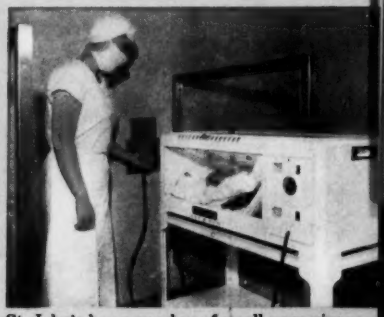
Three 10-cylinder oxygen manifolds, with automatic controls, provide a constant supply of oxygen to 148 NCG wall outlets.

Comfortable, beautifully appointed rooms lend a restful atmosphere to the modern facilities at St. John's.

A ready flow of oxygen is always available in St. John's well-equipped emergency room.



Caesarean Section operating rooms, adjacent to delivery rooms, provide immediate surgical care of patients.



St. John's has a number of small nurseries rather than the usual one or more large ones. Each cubicle has its own oxygen supply.

GET AN OXYGEN PIPING SURVEY—WITHOUT OBLIGATION

You can easily get all the facts about an oxygen piping system for *your* hospital—whether for new construction or existing buildings. NCG engineers will gladly survey your needs and give recommendations, plans and estimates—without obligation on your part. Write to the address at the right or to your nearest NCG office.

NCG®

MEDICAL SERVICES **MEDICAL DIVISION**

NATIONAL CYLINDER GAS COMPANY

840 NORTH MICHIGAN AVENUE • CHICAGO 11, ILLINOIS

Offices in 52 Cities

Where Proper Rest Is The Test–

U. S. KOYLON FOAM MATTRESSES

★ Double-cored Construction For Greater Comfort, Greater Ventilation and Reversibility

Guest-tested in hotels, hospitals, motels and institutions of all kinds, the U. S. Koylon Foam mattress meets all the exacting requirements of transient use.

It provides the ultimate in luxurious comfort, yet it is most economical because it practically eliminates renovation.

U. S. Koylon Foam is lightweight for easy housekeeping . . . non-lumping . . . sag-proof. Its superior one-piece molded, double-cored construction assures correct body support at every point of contact.

Write for further information about U. S. Koylon Foam Mattresses and U. S. Koylon Foam Pillows for hotels, hospitals and institutions

U.S. Koylon® FOAM

HOSPITAL CHECK LIST of U. S. Koylon Features

- Full measure of foam; full length, full width, full depth.
- Non-allergenic
- Easy to sterilize
- Sag-proof
- Washable
- Vermin-proof
- Removable ticking
- Uniform support
- Non-chafing
- Cool, self ventilating
- Reversible
- Lightweight

UNITED STATES RUBBER COMPANY

ROCKEFELLER CENTER, NEW YORK

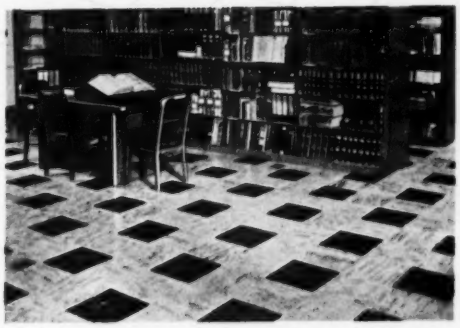
Compare

Johns-Manville TERRAFLEX PLASTIC TILE

(made of vinyl plastic and asbestos)

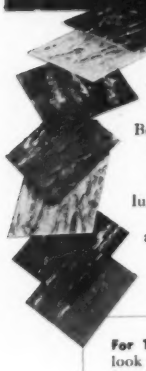
...for longer wear

Johns-Manville, the pioneer in vinyl plastic flooring, made the first installation of this type floor in 1933 and 1934 at the Chicago World's Fair. Twenty million people walked over this unique new plastic floor tile during these years, and accurate micrometer measurements before and after showed no appreciable wear. The same tile, reinstalled in another location is still in use today! It still looks like new!



...for clearer colors

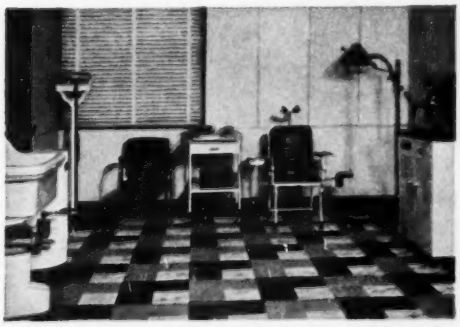
Choose from a large range of Terraflex colors that have clearer, brighter tones than ever before obtainable in resilient floor covering. These colors will not fade, can not wash out and will never lose their sheen from constant wear. Johns-Manville Terraflex will keep its first-day-newness a lifetime.



...for less care

Because of its nonporous surface, Terraflex* Plastic Tile can be cleaned without scrubbing, will stay bright without waxing (although, waxing will give it additional luster). Terraflex Plastic Tile is unaffected by grease, oil, alkaline moisture, and mild acid solutions. Its resistance to moisture makes it ideal for below-grade and on-grade installations.

*Reg. U.S. Pat. Off.



For THE BEST there is in flooring— look to Johns-Manville Terraflex. Send for a free brochure showing the full color line of Johns-Manville Terraflex Plastic Tile and Asphalt Tile. Write Johns-Manville, Box 60, New York 16, N. Y.

JOHNS-MANVILLE JM PRODUCTS

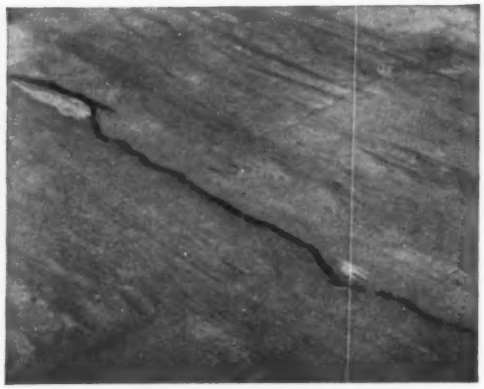
Johns-Manville

TERRAFLEX AND ASPHALT TILE FLOORING

DON'T TAKE YOUR ROOF FOR GRANTED

Get a Built-Up Roof Survey *FREE* of charge!

Water entering masonry parapet and abutting walls often freezes—causing spalling or open brick joints which lead to leaks and damage to the building.



Expansion and contraction, vibration or other distortion often cause cracks in the roof deck—cracks that develop into costly leaks and accelerate roof deterioration.

The *FREE* Roof Survey Report helps you avoid costly roof failures such as those shown above. It tells exactly what condition your roof is in, helps you plan roofing maintenance.

EVEN though your roof doesn't *seem* to be leaking, it may be in need of attention. Many a roof with torn flashings, dried-out felts, even rotted decks has been assumed to be in "good condition."

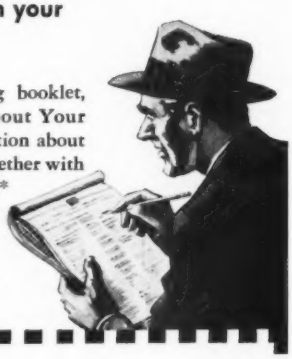
To anticipate costly damage, often hidden, and numerous repair bills, hundreds of plant engineers and maintenance executives have already used the free Johns-Manville Roof Survey Report.

The Roof Survey Report is an accurate picture made by a roofing *expert,* the J-M approved Built-Up Roofing Contractor. It covers all critical areas—flashings, decks, roofing felts, parapet walls, skylights, etc. And it will cost you only the trouble of asking for it.

JOHNS-MANVILLE JM PRODUCTS

*Reg. U. S. Pat. Off.

Let us send you the interesting booklet, "Things You Should Know About Your Roof." It gives complete information about the *free* J-M Roof Survey Plan together with the full story of the J-M Flexstone* Asbestos Roof and the Asbestile* Flashing System. Write Johns-Manville, Dept. MH, Box 158, New York 16, N. Y. In Canada, write 199 Bay St., Toronto 1, Ont.



Get this free survey now!

Johns-Manville, Box 158,
Dept.MH, New York 16, N. Y.

Please send me the free booklet, "Things You Should Know About Your Roof," and have your Approved Built-Up Roofing Contractor see us about making a free survey.

Name _____

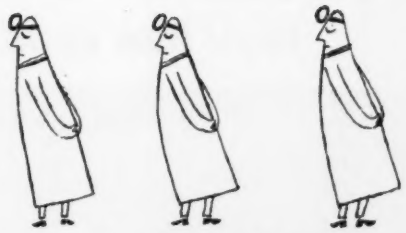
Address _____

Johns-Manville FLEXSTONE* Built-Up Roofs

ASBESTOS CORRUGATED TRANSITE* • ACOUSTICAL CEILINGS

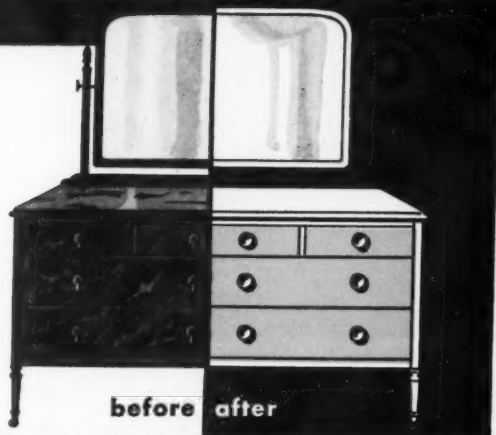
DECORATIVE FLOORS • MOVABLE WALLS • ETC.

sick furniture?



nu-grain has the cure!

NOW, YOUR OLD METAL OR WOOD FURNITURE CAN BE MADE NEW AT NU-GRAIN!*



Nu-Grain refinishers can give your old metal or wood furniture a healthy, new look!

Nu-Grain refinishes and modernizes old dark furniture to colorful new decorator beauty!

Nu-Grain services are economical! Saves up to 50% of the cost of new hospital furniture.

*Nu-Grain is not a paint, it is an at-the-factory process.

Nu-Grain

Saves money!
Increases efficiency!
Raises patient morale!

Naturally beautiful!
9 decorator colors—

Nu-Grain lowers maintenance costs!
Stays below your budget!

Raise patient morale while lowering operating expense with Nu-Grain. Nu-Grain color and beauty create a restful, homelike atmosphere. Consult Nu-Grain now! See for yourself how the Nu-Grain hospital furniture modernization plan will save you up to 50% of the cost of new furniture, and you will have your quality furniture that cannot be duplicated today.

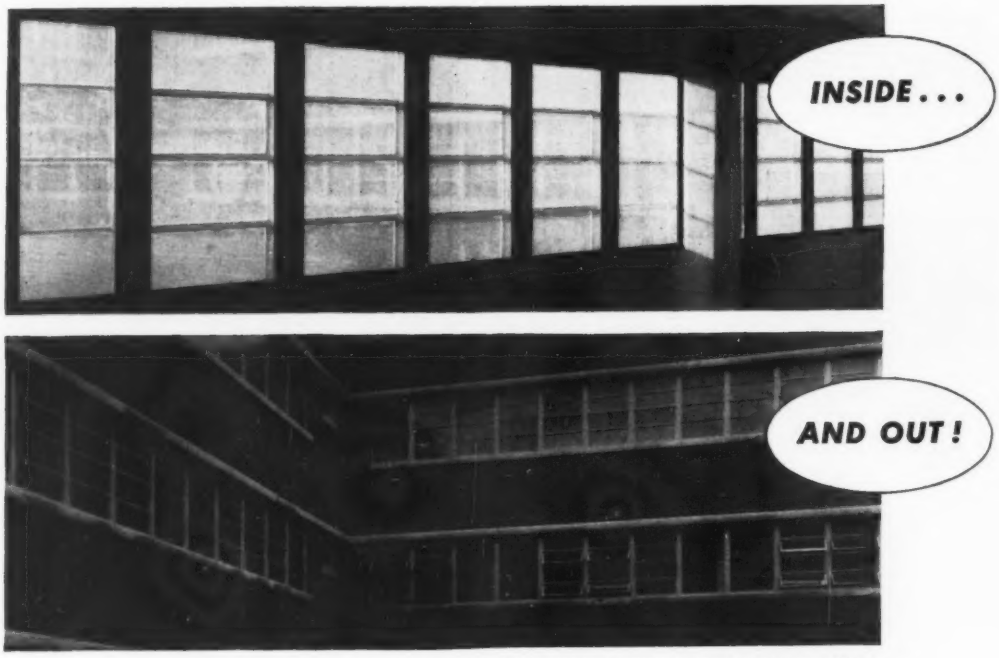
Act now! Write or call for more details. There are 5 Nu-Grain branches, in New York, Cleveland, Detroit, Chicago, and Miami. Our representative will call at absolutely no obligation to you.

nu-grain CORPORATION OF AMERICA

NEW YORK	CHICAGO	CLEVELAND	DETROIT	MIAMI
1775 Broadway	6033 S.	4901 Perkins	32 Duffield	P.O. Box 211
Circle 7-1928	Lafayette	EXpress 1-7025	WOodward	(Allapatah Sta.)
	Butterfield		3-3922	5501 N.W. 36th
	8-6026			Phone: 88-8738

Name_____ h
Hospital_____
Address_____
City_____ **Zone**____ **State**____

New PSYCHIATRIC WINDOWS
look like regular windows . . .



NEW FENESTRA PSYCHIATRIC PACKAGE WINDOWS in Philadelphia State Hospital, Byberry, Pa. *Architect:* H. L. Shay, Philadelphia. *Contractor:* Wark & Co., Philadelphia.

That's important from the standpoint of the appearance of your hospital. It is *vital* to the improvement of your mental patients.

Fenestra* Psychiatric Package Windows don't give your hospital a jail-like look—they don't *look* like psychiatric windows. Yet their design and their special screens give your patients maximum protection.

This modern window "package" includes the graceful awning type Fenestra Steel Window with smooth-working operator and removable adjuster handle (bronze), special steel casing, plus your choice of three types of flush-mounted inside screens: *DETENTION SCREEN* for maximum restraint (the tremendously strong mesh is attached to shock absorbers built in the frame), *PROTECTION SCREEN* for less disturbed patients, or *INSECT SCREEN* for general and administrative sections of your hospital.

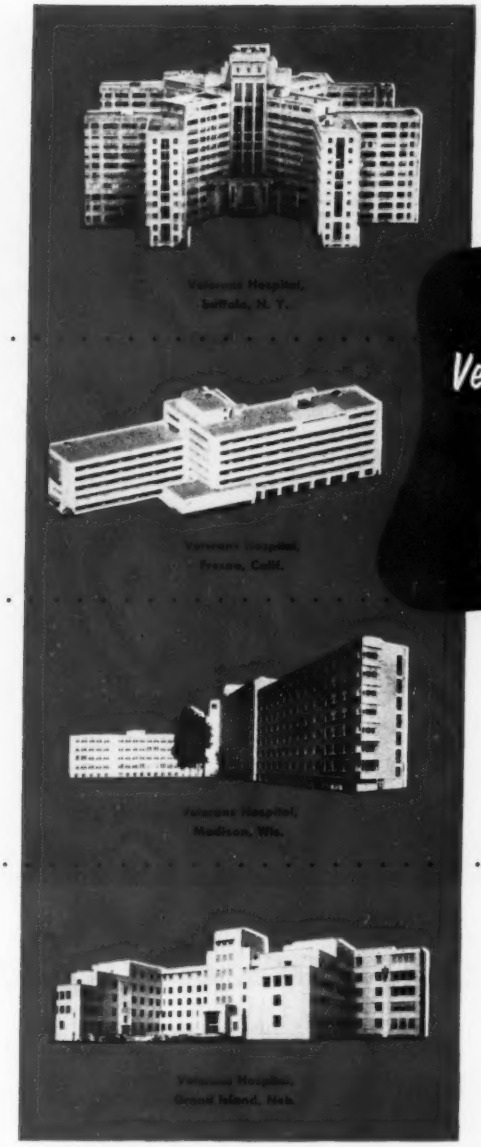
There are no sills to climb on. No sharp corners. No way for patients to get at the glass. All-weather ventilation, controlled without even touching the screen. And the windows are washed inside and outside from *inside* the room.

***Fenestra* Hot-Dip Galvanized Windows never need painting!** To eliminate maintenance-painting, Fenestra Windows are available Super Hot-Dip Galvanized (on special order), from America's only plant especially designed to hot-dip galvanize steel windows. Get complete information . . . call your Fenestra Representative (he's listed in the yellow pages of your phone book), or write Detroit Steel Products Company, Dept. MH-10, 2258 East Grand Boulevard, Detroit 11, Michigan.

*®

Fenestra PSYCHIATRIC PACKAGE WINDOWS

Steel Window • Steel Casing • Screen • Operator
Removable Bronze Adjuster Handle



Veterans Hospital, Buffalo, N. Y.

Veterans Hospital, Fresno, Calif.

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Veterans Hospital, Grand Island, Neb.

NEW Veterans Administration Hospitals Choose AMERICAN Laundry Equipment

• Thirty-nine new Veterans Administration Hospitals, in all parts of the country, have chosen AMERICAN labor-saving, automatic equipment for their laundry departments.

Each installation boasts automatic unloading washers and extractors, which save labor and cut washroom costs to the minimum. Automatic folders neatly fold large linens as they come from high-production ironers. Specialized press units speedily machine-iron uniforms, gowns, shirts and other hospital apparel.

Like most of the leading hospitals throughout the world, these V. A. Hospitals are benefiting by AMERICAN'S experience and leadership in the laundry equipment field. Your hospital can benefit too. Write today for our Hospital Laundry Consultant to call.

The AMERICAN LAUNDRY MACHINERY CO.

CINCINNATI 12, OHIO

Other AMERICAN-Equipped Veterans Hospitals

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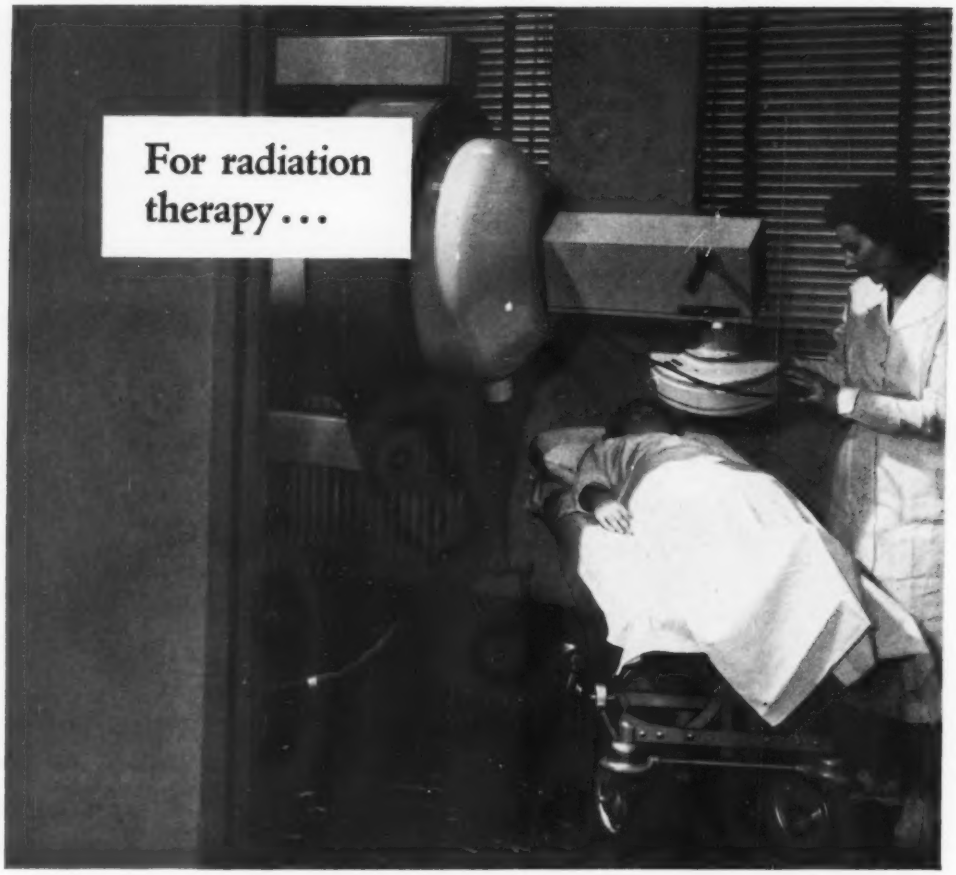
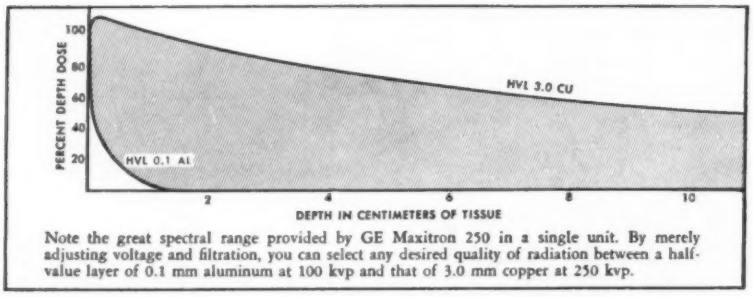
Chicago, Ill.	Miles City, Mont.	Shreveport, La.
Cincinnati, Ohio	Minot, N.D.	Spokane, Wash.
Clarksburg, W. Va.	New Orleans, La.	

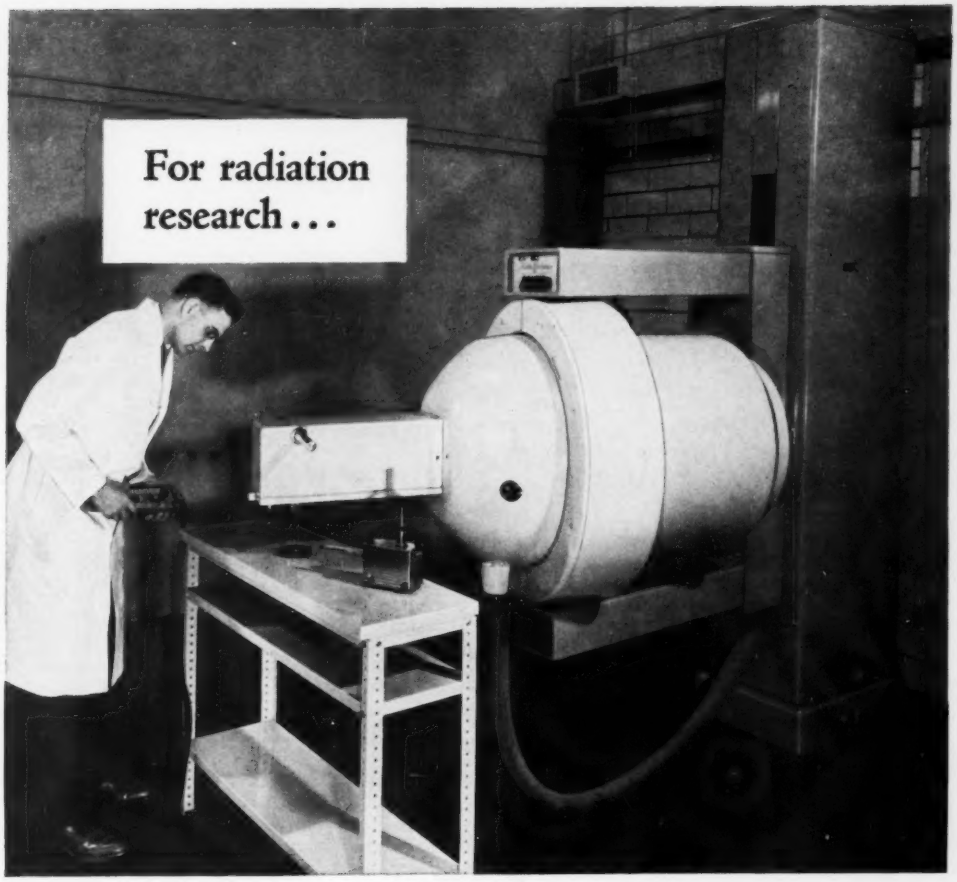


Maxitron 250 offers



Note the great spectral range provided by GE Maxitron 250 in a single unit. By merely adjusting voltage and filtration, you can select any desired quality of radiation between a half-value layer of 0.1 mm aluminum at 100 kvp and that of 3.0 mm copper at 250 kvp.

You can put your confidence in



unmatched output range

No other medium-voltage therapy equipment can match the versatility of the GE Maxitron 250. Clinics with heavy treatment schedules . . . laboratories with a wide range of research projects . . . or institutions desiring to combine treatment and research — will find Maxitron 250 the logical selection for all needs.

For example, the laboratory can change instantly from soft radiation, needed to work with biological samples, to hard radiation necessary for large animals. Similarly, treatment output can be quickly varied from superficial areas to deep-seated tumors. Under all conditions, dosage control is precise.

Yes, Maxitron 250 is the only *single unit* that combines so many advances, so many refinements. And, like all GE products, it's one you can depend on for reliable day in, day out service. Ask your GE x-ray representative for detailed information. To get illustrated literature, write X-Ray Department, General Electric Company, Milwaukee 1, Wis., Rm. H-10.

GENERAL ELECTRIC

What do we mean

Good hospital lighting *can* mean many things to many people. To the patient, good local lighting means a measure of comfort and convenience . . . and the reassurance that inevitably results from the knowledge that he is in the hands of a well-managed, up-to-the-minute organization.

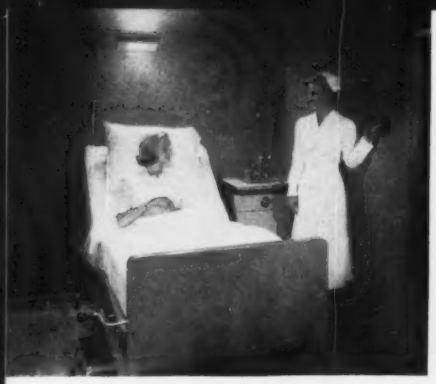
To the hospital visitor . . . especially to the patients' loved ones . . . good lighting means a lasting impression of 20th Century efficiency and the highest standards of cleanliness . . . and the reassurance inherent in these benefits.

To the staff . . . professional and non-professional alike . . . good general lighting means a more pleasant place to work and freedom from tension and nervous fatigue due to eyestrain.

And to the hospital administrator, good lighting means a staff that works better, more efficiently . . . with fewer mistakes and less loss of time, effort, and money due to employee turnover.

In short, good hospital lighting means better "human relations". . . greater public acceptance. And even when hospital beds are at a premium, a favorable public attitude is important to *every* hospital.

Equipment courtesy of
A. S. Aloe Company
General Offices—St. Louis, Mo.



Soft, indirect general purpose lighting is controlled by nurse from a switch panel inside Patient Room door. Day-Brite Bed Lamps are designed for maximum patient comfort and convenience . . . are built for years of trouble-free performance.

Recessed Day-Brite Nite Lights are also controlled from a switch panel inside the Patient Room door, provide up to 100 watts of illumination—ample for normal patient needs. They're ideal for hospital corridors and wards, too.

More and more of the nation's hospitals are going Day-Brite throughout. Because Day-Brite provides the quantity and quality of illumination that creates better working conditions for the staff and a more pleasant atmosphere for patients.

by Good Hospital Lighting?

GOOD HOSPITAL LIGHTING starts with the patient's room . . . "home" to the person who must live there for days or weeks or months. Good lighting takes some of the "sick" out of the sick room . . . helps create a more comfortable, more relaxing atmosphere.

For example, in a typical Day-Brite lighted private or semi-private room (like the one pictured on the opposite page), there are no harsh brightness contrasts common with ordinary ceiling fixtures. Patients get both direct light for reading and soft, indirect illumination for general use from a single glare-proof bed lamp that has been specifically designed for his comfort and convenience.

The 3-lamp Day-Brite Bed Light is mounted 7-feet up on the wall at the rear of the patient's bed . . . out of the patient's reach. A pull switch enables him to turn on the 60-watt reading lamp at will. End lamps for indirect lighting are controlled by the nurse at the door. A handy electrical outlet completes this Day-Brite unit.

On the ward, Day-Brite Bed Lamps using a single direct-beam reading lamp are ideal supplements to general ceiling lighting.

Aside from decidedly more comfortable lighting, there are other qualities that make Day-Brite your best bet in patient room lighting. Day-Brite stainless steel construction, for example, makes these fixtures easier to keep clean . . . gives them a permanent finish that preserves a truly modern appearance for years and years.

Important, too, is the glass top-side panelling that helps diffuse light and protects against dust and dirt deposits that cut down efficiency and create maintenance problems. And Day-Brite Bed Lamps are ventilated at top and bottom for cooler, safer operation. All Day-Brite fixtures are Underwriter Approved, of course.

In the patient's lavatory, Day-Brite Lavatory Units using one 50 or 60 watt lamp for direct/indirect illumination are also of stainless steel construction and feature the glass top, convenience receptacle, and top and bottom ventilation.

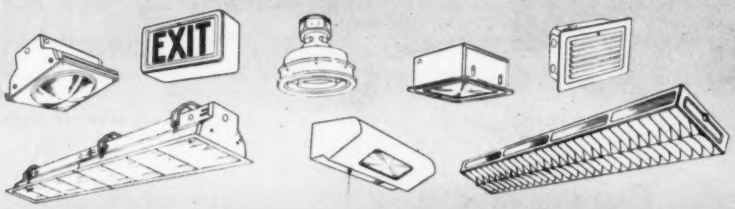
For after visiting hours, Day-Brite louvered hinged face Nite Lights—with wattages up to 100—provide ample illumination for normal sick room needs. These recessed units are usually placed 24 inches from the floor to right or left of the door. Staggered at intervals of 18 feet, Day-Brite Nite Lights are ideal for hospital corridors, too.

Patient Room lighting by Day-Brite is amazingly simple and inexpensive. It provides really comfortable illumination for the patient, and its remote control features for indirect and night lighting save time and trouble for busy hospital nurses.

There's a Day-Brite fixture for practically every hospital lighting need—for lobbies and admitting rooms, for corridors, offices and clinics; for central supply rooms and pharmacies and hospital laboratories; for every service area. Day-Brite has long been an outstanding leader in the manufacturing of the finest industrial, commercial, and hospital lighting fixtures. Why not let Day-Brite's experienced engineers help solve your hospital lighting problem?

For complete information, WRITE: Day-Brite Lighting, Inc., 5455 Bulwer Ave., St. Louis 7, Mo. In Canada: Amalgamated Electric Corp., Ltd., Toronto 6, Ontario.

"Decidedly Better" Day-Brite Fixtures for Decidedly Better Hospital Lighting



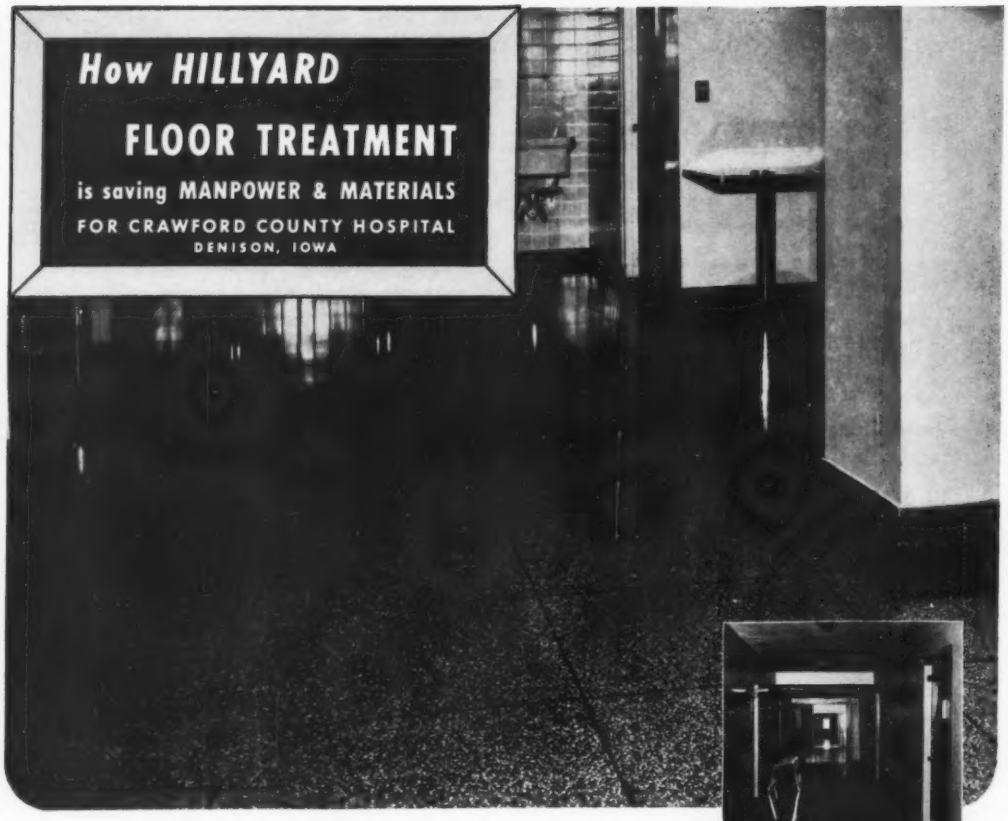
"DECIDEDLY BETTER"
DAY-BRITE
Lighting Fixtures

264

How HILLYARD FLOOR TREATMENT

is saving MANPOWER & MATERIALS

FOR CRAWFORD COUNTY HOSPITAL
DENISON, IOWA



Crawford County Memorial Hospital Denison, Iowa

Hillyard ONEX-SEAL provides handsome slip-resistant finish, capable of standing great traffic strain and spillage without frequent replacement. Non-greasy HIL-TONE holds dust-up time to a minimum.

All over America those responsible for hospital cleanliness are facing a challenging problem. Hospitals *must* be kept spotless and yet manpower is scarce and costly.

The need, therefore, is to make the fullest use of materials, the most effective use of time. The Crawford County Memorial Hospital, Denison, Iowa, found the answer in Hillyard quality floor products—which provides 3-way savings.

1. Saves materials—because LESS of quality Hillyard products are needed. They hold up longer.
2. Saves men—because Hillyard methods, specialized for particular floors take less time—hold crews to a minimum.
3. Saves money—because protective Hillyard treatment pays off in PREVENTIVE MAINTENANCE. Costs you less in the long run.

Specialists in Hospital Maintenance for nearly 50 years.

FLOOR HILLYARD TREATMENTS

HIA HOSPITAL INDUSTRIES ASSOCIATION

St. Joseph, Missouri

So Call on HILLYARD

A treatment for every type of floor — and a savings on every maintenance job.

. . . on your staff not your payroll.

Write for FREE HELP Today

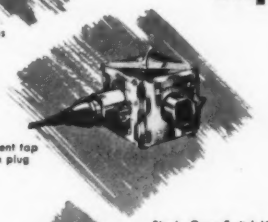
The Hillyard Maintaineer (Floor Expert) will plan you a program of PREVENTIVE FLOOR MAINTENANCE for your hospital. His advice is free.

Here's YOUR Protection
for Patients, Personnel, Property

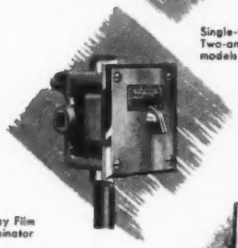
APPLETON

explosion-proof hospital equipment

AA-51 Series Lighting Fixtures

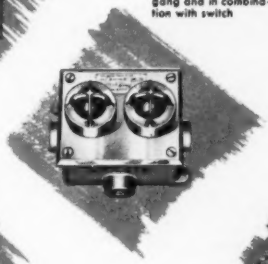


Portable current tap with feed-in plug

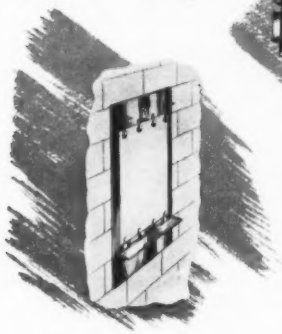


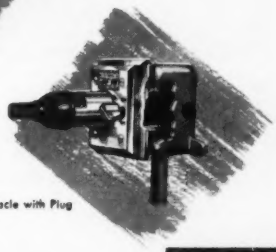
Single-Gang Switch Unilet. Two-and three-gang models also available

Two-gang Pilot Lights. Available in single gang and in combination with switch

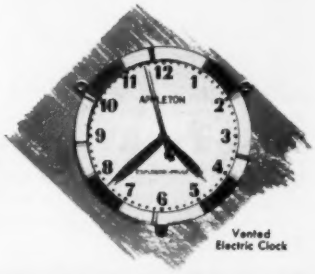


X-Ray Film Illuminator





Receptacle with Plug



Vented Electric Clock

Appleton Explosion-Proof Hospital equipment provides certain protection against fire and explosion hazards in anesthesia and operating rooms by completely confining electrical sparks that may ignite vapors and gases. Made for new installations, as well as for replacements in old buildings, Appleton Explosion-Proof Hospital equipment is constructed in strict accordance with Underwriter's Laboratories requirements for use in hazardous locations, Class I, Groups C and D.

Sold Through Electrical Wholesalers

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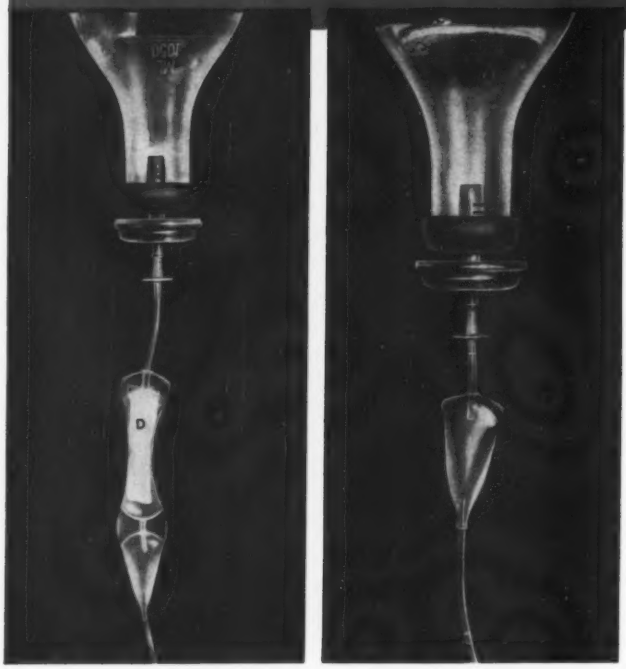
APPLETON ELECTRIC PRODUCTS

This is it! Introducing the

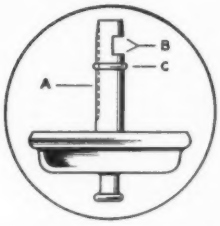
TEL-O-VAC®

DISPENSING SEAL



A 3-function dispensing closure that simplifies the administration of intravenous fluids and blood, and serves as a vacuum seal in the preparation of sterile solutions.

- NO AIR VENT TUBE IS EVER REQUIRED
- STOPPER IS NEVER REMOVED FROM CONTAINER



The stem of the Tel-O-Vac Seal is fabricated to include a 2-way air vent (A) and inside strainer (B) as illustrated. Note supporting ring (C) which establishes the proper point at which the Seal should be set prior to attachment of Fenwal Universal Sets.

Fenwal UNIVERSAL SETS

Disposable Dispensing Sets for the administration of intravenous solutions and blood. Both Fluids and Blood Sets may be used with all types of conventional closures as well as the recently devised Fenwal Blood Pack*.

Permits Better Control of Flow

Infusion time can be reduced by completely filling Filter Chamber (D) with blood before starting the transfusion. This is readily done by gently squeezing the plastic filter. The flexible character of both filter and drip chambers affords a means of creating most favorable conditions for steady, uninterrupted results.

The Fenwal Plastic Filter Chamber may be gently squeezed to free or break up any blood clots that may tend to clog at the outlet tube or needle.

*Sack, Theodore et al, The Preservation of Whole ACD Blood Collected, Stored, and Transfused in Plastic Equipment, Surg. Gyn. Obst. : 95, 113-119, 1952.
Walter, Carl, W., A New Technic for Collecting, Storage and Administration of Unadulterated Whole Blood. Surgical Forum.
Walter, Carl W., and Murphy, Wm. P. Jr., A Closed Gravity Technic for the preservation of Whole Blood in ACD Solution utilizing Plastic Equipment. Surg. Gyn. Obst.: 94, 687, 1952.

THE SOLUTION DESIRED — THE Fenwal SYSTEM — AT THE INSTANT REQUIRED

Fenwal POUR-O-VAC® Seals

A vacuum closure that provides a practical means of avoiding wasteful, time-consuming and questionably scientific methods of sealing and handling surgical solutions. When hermetic seal is broken, contents pour from a non-drip, sterile lip.

Pour-O-Vac closures also provide a dust-proof seal for remaining contents when only partial contents of a container is used. Any need to use gauze, cotton, paper, string or tape to effect a make-shift seal of questionable efficiency is completely eliminated. In addition, the possibility of breakage or chipping damage to container lips is greatly reduced.

Pour-O-Vac Seals are reusable . . . may be repeatedly sterilized . . . are interchangeable for use with 500, 1000, 1500, 2000, and 3000 ml. Fenwal Containers. *NOTE: It is important to stress that physical construction of Pour-O-Vac Seals for external fluids cannot be confused with Tel-O-Vac Seals designed for the dispensing of intravenous fluids.*

Fenwal TEL-O-SEAL® Closures

Fenwal vacuum containers of Pyrex Brand Glass and Tel-O-Seal hermetic closures provide a practical means of insuring the sterility of hospital prepared parenteral fluids over long periods of storage. The sterility factor may be checked periodically without breaking the hermetic seal or contaminating the contents.

Following sterilization, the vacuum formed during the cooling phase produces a water-hammer when containers are inverted or jarred. This audible signal instantly indicates that vacuum seal has not been broken, and affords a simple, reliable check immediately prior to administration of contents.

The Fenwal AMP-O-VAC®

As a factual equivalent of a *reusable ampule*, the Amp-O-Vac closure and container provides a practical means of reducing waste of novocaine and similar medications by permitting withdrawals, as required, without exposing the balance of contents to the air.

Units are available in 75 ml. and 150 ml. sizes. The hermetic closures are especially designed for puncture-sealing withdrawal, and may be repeatedly sterilized and reused as often as required. Amp-O-Vac units provide desirable economies in time, medication and expense.

ALL FENWAL CONTAINERS ARE MADE OF PYREX BRAND GLASS

Lifeline ACCURETTES® . . . another basic first!

A new and simplified technic for the accurate preparation of parenteral fluids.

Accurettes eliminate any weighing, mixing, filtering and washing of preparation glassware in preparing accurate I.V. and surgical fluids.

COLOR IDENTIFICATION For the safety afforded by instant, visible identification, the various Accurettes include a color tint. This tint instantly reveals the type and dilution of the contents.

SAVES TIME • SAVES LABOR • SAVES SUPPLIES AND EQUIPMENT • REDUCES CONTAINER BREAKAGE • CUTS MAINTENANCE COSTS

All parenteral solution compounds are available in Accurette form.

The improved Fenwal Container has an added, accurately-calibrated, line and numeral at 1050 ml. capacity. Proportional calibrations are also shown on other size containers.

Drop one Accurette into container . . . add distilled water to calibration . . . sterilize—*as simple as that!*

LIFELINE® SERVICE

The adopted sales policy of the Macalaster Bicknell Parenteral Corporation is that of direct sales to hospitals and scientific institutions.

In addition to the many items of supplies and equipment that constitute the universally popular Fenwal System, **LIFELINE** Service will also include a complete line of general hospital supplies, scientific glassware, and major equipment for the surgical services, central sterile supply department, pharmacy, clinical and research laboratories, and allied utility services.

We invite your inquiry

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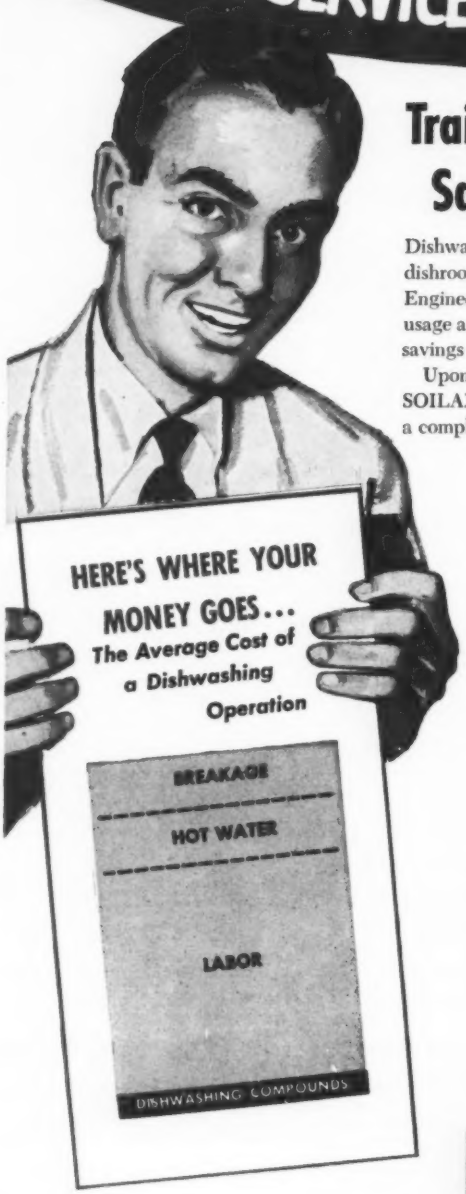
THE SOLUTION DESIRED THE Fenwal SYSTEM **AT THE INSTANT REQUIRED**

SOILAX SERVICE cuts dishroom costs



Trained Soilax Engineers Can Save You Money 3 Ways!

Dishwashing compounds account for less than 5% of your total dishroom cost. To save you money—*real money*—the SOILAX Engineer will make a detailed study of breakage, hot water usage and labor costs . . . will show you how to make substantial savings on items that account for 95% of your dishroom costs.

Upon request—*without charge or obligation*—the trained SOILAX Engineer will survey your dishroom. He will render a complete report on his suggestions and recommendations.

1. ON BREAKAGE COSTS

He will show you the most efficient methods of handling dishes and glassware, the proper use of racks, wooden slats, etc. He will also demonstrate proper sorting and handling of dishes and glassware by waitresses and bus boys to cut down breakage.

2. ON HOT WATER COSTS

He will check complete dishwashing department for leaky valves. He will check temperatures and if not up to sanitation standards will make necessary recommendations.

3. ON LABOR COSTS

He will: (a) show you how to eliminate hand toweling of silverware, dishes and glassware; (b) explain how you can eliminate dipping and scouring of dishes by prescribing the right compound and installing automatic methods of compound control; (c) point out improved bussing techniques, pre-sorting, scrapping and racking; (d) offer new ideas on dishroom layout and teach operators proper use and care of equipment. All this—plus personal monthly follow-through to help you maintain peak dishroom efficiency.

This is a FREE SOILAX SERVICE!

SEND COUPON TODAY!

New another exclusive TOLEDO first!

A FREE service-inspection

After installation of your new Toledo Dishwasher or Food Machine by your Toledo Dealer—the Toledo factory-trained service expert will call to check the installation and operation. THIS SERVICE IS WITHOUT COST TO YOU. It assures that you will get in full the fine performance built into Toledo Kitchen Machines.

It is another Toledo first—a feature that only Toledo with its NATION-WIDE network of factory-trained service can offer. When you buy a Toledo your dealer and Toledo service are a team to bring you the greatest value and dependability from your investment. Toledo Scale Co., Rochester Division, 245 Hollenbeck St., Rochester, N. Y.

TODAY IT'S

TOLEDO®

ALL THE WAY!

Small Hospital Questions

Contaminated Linens

Question: We have been advised that it is not necessary for us to provide a special washer for contaminated linens in our laundry, but that contaminated linens can be safely run through the laundry with ordinary washing. If this is so, a substantial saving could be effected. What is your opinion? —F.W., Ill.

ANSWER: In modern practice, proper use of water and detergents at the optimum will provide adequate sterilization of contaminated linens. Most authorities today agree that it is not necessary to provide separate equipment in the hospital laundry for processing contaminated material. Nevertheless, good linen sorting and laundry technic requires that contaminated linens be separately handled. The method in common use for handling contaminated linens is the "bag" method. Contaminated linens are placed in a colored bag, frequently dark blue, and are then handled with extreme caution to prevent any possibility of the spread of infection. Frequently these linens are inserted in the washer and washed in the bag as a further precautionary measure. Whatever the specific method used, however, it is important for contaminated linens to be handled separately, from disposal through the washing process.

Nurse Salary Ratio

Question: What is a proper and reasonable ratio between the salary of the professional nurse and that of the practical nurse working in the hospital?—C.M., Ohio

ANSWER: Surveys indicate the prevailing ratio of professional to practical nurses' salaries is four to three. In some areas, of course, the laws of supply and demand in both classifications may require variations from this standard on either side. However, experience would indicate that both groups are satisfied when rates are established at about these levels.

Bonus for Night Work

Question: Do hospitals commonly pay a bonus to nurses and other employes working at night and on week-end and holiday shifts?—P.C., Pa.

ANSWER: Frequently. In the case of nurses, especially, it is common practice to advance the salary somewhat (usually in the neighborhood of 5 to 7½ per cent) for those on regular night duty. In most institutions, week-end and holiday duty is on a rotation basis, making the payment of salary increments for these shifts unnecessary. Payment of higher salaries for ward attendants, orderlies, maids and other employes on night duty is less well established but may be necessary on occasion to offset the disinclination of many employes to accept these assignments.

Purchasing Authority

Question: Should the administrator of a small hospital attempt to do all the purchasing, or should he delegate this authority to department heads? If he must perform this function himself, how can the administrator control the amount of time spent with sales representatives of various companies in such a way as to enable him to accomplish all his other duties with as little loss of time as possible?—J.E., Fla.

ANSWER: Good purchasing practice requires that purchasing control be centralized in a single office, not dispersed throughout the hospital, with various departmental executives given final authority for purchasing supplies for their own departmental operations. When the hospital and the volume of purchases are not large enough to justify the employment of a full-time purchasing officer, this function may be successfully combined with some other responsibility. In some hospitals, for example, a single executive is responsible for purchasing and personnel; purchasing may also be combined with pharmacy operation, business office management and other executive functions. Frequently, however, the administrator must himself assume the duties of purchasing agent. When this is the case, certain times may be set aside each week or each month for interviewing sales representatives, so that the administrator will not be interrupted constantly in the performance of his many other executive duties.

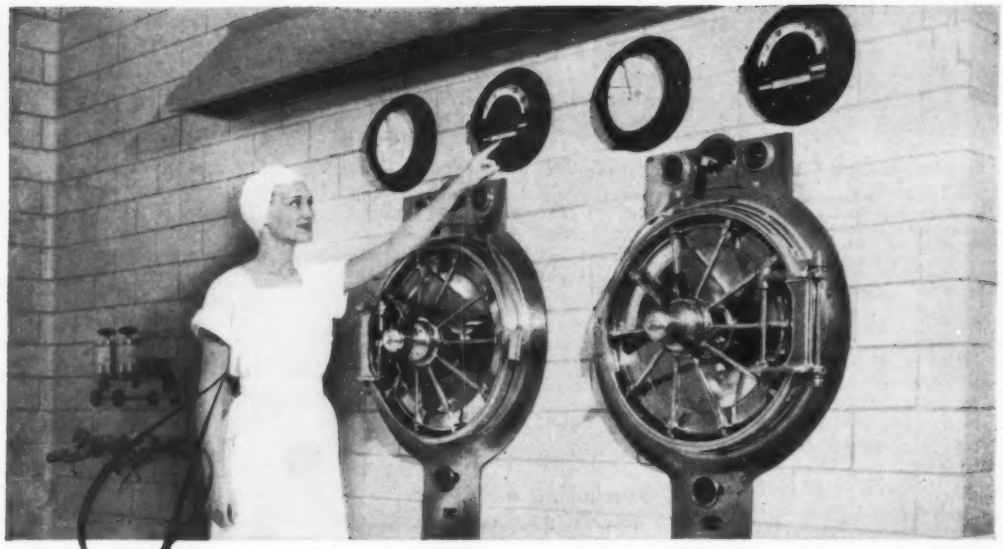
Unless this scheduling of the administrator's time is done carefully, it may work a hardship on representatives with large territories and many hospital calls to make. If all supplying manufacturers and dealers are notified in a friendly letter explaining the hospital's problem and requesting that sales calls be made only at the stated hours, misunderstandings and interruptions can be avoided for the most part. Another measure that may save time and make purchasing practice more effective is the delegation of responsibility for interviewing sales representatives to certain stated departmental executives, again at scheduled hours. The department heads may then review problems and products with the salesmen and make recommendations to the administrator or other purchasing authority for final action.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala., William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

"Surgical Fund"

Question: Our hospital has a rule that doctors do not collect fees for service to staff patients. Occasionally, however, doctors' fees are collected in accident cases. Also, we are paid a stipend by the government for the initial examination of staff prenatal cases. These fees are all deposited in what we call our "surgical fund." Your advice would be appreciated as to the different methods of spending such a fund and its management and control.—B.D.T., Kan.

ANSWER: It would seem that a fund of the type described here could most appropriately be administered by a special committee of the medical staff, in cooperation with the administrator of the hospital. Such a committee would consider various patient needs, research projects, medical library requirements and other small needs that might suitably be met from a small fund administered by the medical staff.



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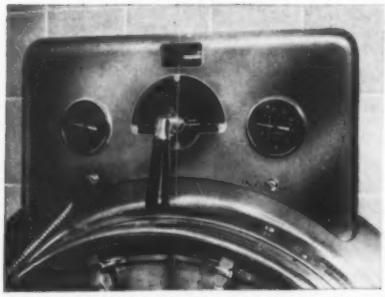

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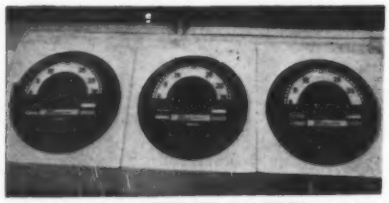

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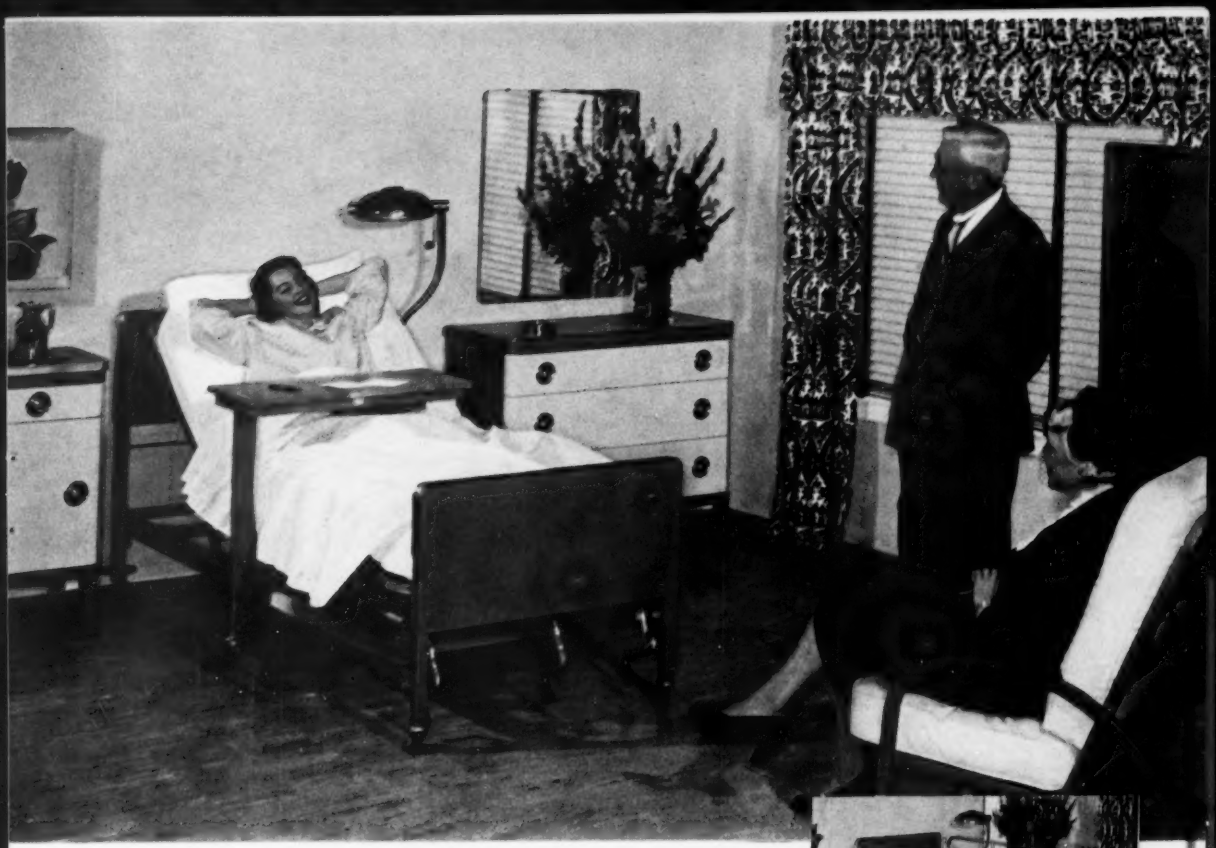

Experience leads St. Joseph's Hospital to SIMMONS

"My previous happy experiences with the high quality of Simmons equipment had a direct influence upon its selection for all of the rooms in the new wing of our hospital."
Sister Mary Ancilla, Mother Superior, St. Joseph's Hospital, Menominee, Mich.

Here's that grand old story again—of Simmons quality making lasting friendships which Simmons, too, never forgets! Such friendships have real meaning to everybody in Menominee—citizens who become patients, as well as doctors, nurses, Sister Mary Ancilla and the administrative staff.

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All 72 beds in the new wing have Vari-Hite All-Purpose Bed Ends. This gives them great flexibility in use. The patient may be raised or lowered at will for treatment. And, the beds may be equipped quickly to handle a Balkan Frame or other fracture equipment, or be provided with safety sides.

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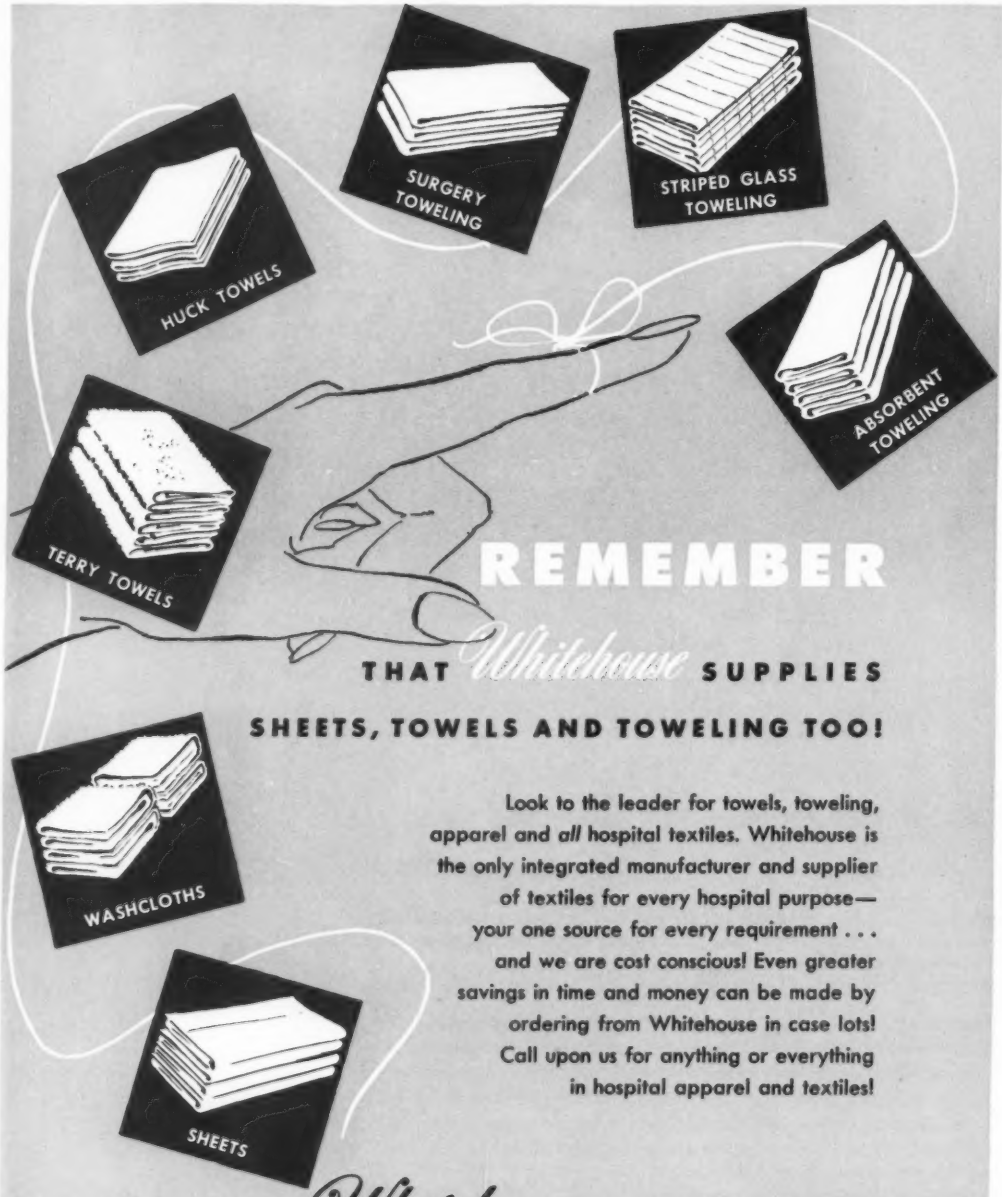

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SUPPLY OUTLOOK BRIGHTENS

It can be said, without shouting the good news, that for the foreseeable future at least the pressure is off on hospital supplies. Government officials who have struggled with the metals shortage for two years now state flatly: "There is no reason for pessimism."

The picture is easing up in the equipment and maintenance fields, as well as in construction. On a few items—beds are one example—there will still be long waits for delivery in many cases, but the problems definitely are not serious.

In one particular field, antibiotics, even the long-range prospect is rosy. This largely can be attributed to action of Defense Production Administration in granting tax relief to four large producers who are planning plant expansion to total more than $15,000,000. Ultimate value of the new equipment, taking into account facilities on which rapid tax amortization has not been allowed, may come to $20,000,000.

Three of the companies will be allowed to write off 50 per cent of the new costs in five years. They are Bristol Laboratories, Inc., East Syracuse, N.Y. ($4,928,785), Charles Pfizer & Co., Long Island ($1,850,000), and Merck & Co., Inc., Danville, Pa. ($1,292,000). An even larger expansion by American Cyanide Co., of Pearl River, N.Y. ($5,280,000), may be written off up to 45 per cent in five years.

The tax relief was granted partly at the urging of other governmental agencies, which were anxious to see more output to allow for civil defense stockpiling of antibiotics. For a time, it is anticipated, there will be no particular market reaction. Eventually, however, private and other purchasers will benefit from the greater production. This will occur because the civil defense medical warehouses, once they are filled, will rotate their perishable supplies back into the civilian market well before the deterioration date approaches.

Defense Production Administration also acted to bolster the future production of medical, optical and surgical instruments when it authorized National Electric Co. of Elmhurst, N.Y., to write off 55 per cent of a $245,800 expansion program within the five years.

NO CONSTRUCTION WORRIES IN SIGHT

Barring another national emergency, officials of the Division of Civilian Health Requirements, Public Health Service, are confident construction supplies will be adequate well into next year. For one thing, the national economy has shown an unexpected resilience in the face of the steel strike. For another, many of the five-year building programs for state and federal hospitals, started in 1946 and 1947, now are drawing to a close, lessening the drain on material set aside for health purposes.

From a purely short-range, technical standpoint, another factor works to the advantage of the hospital construction industry. The third quarter of this year was the biggest, from a construction standpoint, of any since the controls program was imposed. When the steel strike left all schedules up in the air, hospitals and clinics were allowed to plan on getting for the fourth quarter 80 per cent of the amounts of scarce metals used in the record third. For the first quarter of 1953, they will be allowed at least 70 per cent of the amount available in the third quarter. With construction slackening off, this means that the industry is in a fortunate position.

Obviously, Defense Production Administration will have to take cognizance of this situation, which adds up to a form of official and lawful misrepresentation. But by then it is expected that even a realistic across-the-boards rationing will still deliver up all the steel, copper and aluminum needed to expand and maintain the country's hospitals.

CENSUS BUREAU PLANS SURVEY

Still another survey of hospitals is in the making. Officials of U.S. Bureau of the Census already have met with representatives of a dozen national organizations to decide (a) whether the study should be undertaken as part of the 1953 survey of business, (b) the information desired, and (c) format of the questionnaire. At this writing, officials of the bureau are reasonably confident that the health associations consulted will urge that the survey be undertaken.

Thinking now is that one of the fields to be studied will be the old familiar one of sources of income for hospitals, and potential sources. Particularly the study would attempt to determine with some degree of accuracy what percentages of patients pay their hospital bills, how much of the money is raised by insurance benefits, how much by loans, and the financial relationships between welfare agencies and hospitals.

The plan also is to include essential questions to develop statistical information on all types of purchases made by hospitals. On these two points the survey would be covering and reviewing fields well worked in previous years by other surveys.

A third possible field of investigation concerns fringe organizations and facilities, such as nursing and convalescent homes, which do not qualify as hospitals and cannot be or are not licensed. Here the field will be greener.

HILL-BURTON

For the first time since start of the Hill-Burton hospital construction program, the state percentage formula is to be revised to bring it back into line with changes in populations, per capita incomes and hospital needs.

Since 1949 the same tables have been used to determine what portion of a state's total hospital construction costs would be supplied by the federal government. The new schedule will take effect next July 1 and continue at least through June of 1955.

The program has $75,000,000 for commitments to the states during the current fiscal year, $7,500,000 less than last year. The new percentage schedule can't set a dollar value on each state's share, because the actual money will depend on congressional appropriations next year and in 1954. (First column current rate, second column rate set for 1953-55.)

Alabama	70.16	70.58	Nebraska	50.22	50.77
Alaska	50.00	50.00	Nevada	36.00	36.00
Arizona	56.80	56.03	New Hampshire	55.12	24.50
Arkansas	70.26	70.76	New Jersey	41.86	40.62
California	36.09	39.13	New Mexico	62.92	59.66
Colorado	46.84	50.29	New York	34.72	35.46
Connecticut	39.36	38.19	North Carolina	67.62	67.11
Delaware	39.96	34.99	N. Dakota	46.18	55.54
D.C.	35.72	33.56	Ohio	45.51	44.76
Florida	58.44	58.68	Oklahoma	61.84	61.73
Georgia	66.74	66.25	Oregon	43.58	47.60
Hawaii	50.00	50.00	Pennsylvania	47.37	47.39
Idaho	52.54	55.80	Puerto Rico	75.00	75.00
Illinois	39.33	38.89	Rhode Island	47.50	46.39
Indiana	50.85	49.17	South Carolina	70.10	69.73
Iowa	50.68	51.30	S. Dakota	49.13	54.17
Kansas	53.28	53.70	Tennessee	66.99	66.72
Kentucky	67.62	67.23	Texas	57.00	55.29
Louisiana	64.76	64.52	Utah	54.91	55.28
Maine	58.30	58.70	Vermont	58.62	58.31
Maryland	46.67	46.22	Virginia	60.71	59.90
Mass.	46.88	44.93	Virgin Islands	75.00	75.00
Michigan	45.71	45.43	Washington	46.30	44.23
Minnesota	52.98	53.30	W. Va.	61.64	62.88
Mississippi	74.28	75.00	Wisconsin	49.79	49.49
Missouri	52.58	51.62	Wyoming	45.00	45.73
Montana	41.86	46.04			

To the 49 bed hospital at Lebanon, Ore., goes the honor of being the one-thousandth hospital to be completed under the program. It cost $652,510 (U.S. share $193,667) and was dedicated early this month.

LEGION SEEKS FUNDS FOR V.A.

American Legion's medical policy advisory board, under chairmanship of Dr. Leonard G. Rowntree, is making a valiant effort to get more money pledged to Veterans Administration. It is fearful that unless a deficiency appropriation is made available for use in the last three months of the current fiscal year, the V.A. medical care program will suffer crippling damage.

The board currently is attempting to get the budget bureau to approve a "realistic budget" for the next fiscal year. At the same time, it is preparing to ask Congress to come through with the deficiency budget.

Both the bureau and Congress are under fire from the board. Dr. Rowntree said that the board felt the two together were "gradually whittling away" at the V.A. medical program. He said the result is a gradual lowering of quality and a spreading sense of insecurity among V.A. personnel.

Last session Congress cut $31,000,000 from the V.A. budget, after the budget bureau had finished with its boiling down operation. As a result V.A. already has announced it was cutting its average patient load from 102,000 to 99,200. It is also making plans to cut down on the number of home-town care patients to be handled in the months ahead.

FEE-SPLITTING

Although the ethical picture hasn't changed for them, physicians engaged in fee-splitting have received some financial encouragement from the internal revenue bureau. B.I.R. has ruled that in some cases payments made by one physician to another for referral of cases may be deducted from taxable income—but "each case will be decided on its merits."

The ruling tells the split-fee doctors this much:

1. If it is to be deducted, the payment must be "normal, usual and customary in the profession and the community."

2. It must be "appropriate and helpful in obtaining business."

3. It may not be in violation of "sharply defined" national or federal policies as enunciated by a government declaration.

The ruling also reaffirms, in language not too clear, the doctor's right to deduct money paid for "professional assistance," presumably meaning nurses, technicians or other physicians employed on a permanent basis or to perform a specified service.

HEALTH NEEDS COMMISSION

With its most controversial hearings over with, the President's Commission on the Health Needs of the Nation now is engaged in the staggering task of making sense—and recommendations—out of at least 10,000 pages of testimony. Part of it was collected at closed-door panel meetings in Washington, part at open hearings here, and the rest at the regional sessions held around the country.

The climax came early this month at open meetings in Washington, when proponents and opponents of national compulsory health insurance (Truman-Ewing plan) had their days as witnesses. Also discussed, of course, were the alternatives to national health insurance, the voluntary plans which the medical profession has been promoting.

The commission is expected to have all the material digested and facts and recommendations drawn up in form of a report for formal presentation to the White House by the end of this year.

SELECTIVE SERVICE

By March, Selective Service System may be calling on a few Priority III men for active duty—men who were not educated by the government, not deferred for their studies during World War II, but who have not had previous military service. Once they start inducting men from this group, the military planners will be up to their chins in the hottest issue they have struggled with since World War II. The law says that as far as practical all Priority III men must be called before resorting to Priority IV, the veterans. But many Priority III men have had too much experience, and are too old, to fit in well as first lieutenants or naval lieutenants (J.G.). They rate major or colonel or commander positions. But the services, while generally short of doctors as such, aren't particularly short of medical brass. The military would much prefer to reach into Priority IV and pick off a few younger men who had limited service. Yet, under the law they can't do it. One idea receiving some consideration is to lump III and IV together, giving procurement officers a better choice of middle-aged and young men.

TB TOTALS

For years it has been estimated there were about half a million tuberculosis cases in the United States at any one time. Now U.S. Public Health Service and the National Tuberculosis Association, citing an inventory of registered cases and weighted with information learned in x-ray surveys, report that the total is closer to 400,000. Undiscovered cases are said to approximate 110,000, and health departments list 250,000 active cases. An additional 40,000 cases are included to take care of child patients and to allow for underestimation in surveys.

Crumb

HAD a communiqué the other day from our old friend Anastasia, the cryptic hospital critic. "Elderly aunt in hospital several weeks," she related. "Often visit her at mealtimes. Always two slices bread on tray. Aunt hates bread. Nobody notices. Bread keeps coming. Wasteful."

We reported all this to a dietitian we know, and sent her answer along to Anastasia. Soon afterward, we got another note. "So who likes bread pudding?" this said.

Borderland

FROM time to time in these pages, we have considered it our solemn duty to brood about the ethics of consulting services. What happens, we have wondered moodily, when a consultant's financial interest is in conflict with his conscience at a point where the outcome will never be apparent to anybody but himself? Considering the number of times architects say, "Don't build!" and surgeons say, "Don't operate!" we have been satisfied that fee-for-service morality has a high score.

Now, however, comes a report from a friend suggesting how shadowy are the pitfalls for conscience, how many the grays between black and white. A hospital planning consultant, our friend says, makes a practice of lopping off his fee if the client agrees to buy from a certain supply house—represented, in this case, by a relative of the consultant's.

Here is a nice kettle of ethics. The client saves the fee and, presumably, gets his money's worth from the supplier; the consultant sacrifices personal income for family solidarity—an admirable act, possibly, from every point of view except that of competing suppliers. Yet, unquestionably, the relationships here have been subtly changed. Something new has been added—something which is neither fee nor service and thus fits uncomfortably into a fee-for-service arrangement. An accepted practice in business, the exchange of favors for mutual advantage sits with ill grace in a professional office or consulting room, where it may be less sinful, perhaps, than simply gauche. In that dim borderland where the ethics we profess meet the economics we practice, it's often hard to tell the difference.

Masterpiece

WHAT with inflation, politics and all, everybody is a little confused about everything these days, and an organization can certainly be excused for finding itself on both sides of the same issue. The way things are, it takes a good organization to find itself anywhere. Take the case of the American Legion and the American Medical Association, for example. The voluntary medical world, of which the A.M.A. is a part, if not, as it would sometimes seem, the whole, is increasingly disturbed about the expanding power of the Veterans Administration hospital system, and especially the relaxed interpretation of the law which permits care of so many nonservice-connected disabilities at V.A. hospitals—in competition with voluntary hospitals and doctors in private practice. Worrying about this form of socialized medicine, however, doctors and hospital leaders who speak up on the subject find themselves squared off against a formidable opponent—the American Legion.

Got that straight? Now consider this: Speaking at the national convention of the American Legion last month, President Louis H. Bauer of the American Medical Association declared warmly: "The American Medical Association and the American Legion have much in common. Not only are they jointly interested in the health and welfare of the veteran, but

they have also provided the main leadership in the drive against the socialism which is steadily creeping over this country." An A.M.A. release on Dr. Bauer's speech said he added that "American physicians will be forever grateful to the Legion for its early, vigorous and continued support against socialized medicine."

As Macduff said when he found the body: "Confusion now hath made his masterpiece!"

Bowl Game

A BADLY harassed species under the most favorable conditions, hospital cashiers are frequently driven to the rim of insanity by visitors who want change to make a telephone call, buy a newspaper, or avoid the awful wrath of the bus driver, a man who sees red at the sight of green money. To save wear and tear on cashier's nerves, the Bishop Clarkson Hospital at Omaha recently installed a fishbowl, containing $10 in nickels, dimes and quarters, on the cashier's counter. "Make your own change," says a nearby sign. When the bowl fills up with bills, the cashier reloads it with silver, a transaction that is necessary about once a day.

So far, according to *Clarkson Sparks,* the bowl shows a net profit of 2 cents, possibly proving there are honest people around, after all—at these prices, at least.

Move Over, Barnum

THE successful public relations man, a former New York newspaper editor once wrote, must combine the best qualities of John the Baptist and a Mississippi snake doctor. The definition stood for 20 years, but it is no longer valid. Its scope must now be enlarged to include the antic genius of the Seattle public relations character who stage-managed the Ballard Hospital's recent building fund drive.

However reluctantly, Ballard's doctors were persuaded to play a key rôle in this circus. At midnight on the appointed day, doctors on the hospital staff telephoned their patients and neighbors. "Come to Ballard Hospital at once!" they said in urgent tones. "This is an emergency. We need you!" At the same time, ambulances sped through Seattle's quiet streets toward the hospital, sirens wailing.

Thinking dire thoughts of total disaster, residents raced to the hospital, many still in their nightclothes. Arrived there, they were herded into an auditorium, where trustees told them of the emergency need for funds to provide a new building for the crowded hospital.

A few citizens were angry, it was reported, but most took it in good spirit—possibly remembering occasions on which they had aroused their doctors at night for alleged emergencies that faded unexpectedly when acute symptoms vanished before the doctor arrived. Whatever Seattle citizens thought, they gave freely; with this and other stunts, Ballard fund raisers got nearly three times what they asked for in public subscriptions. Snake doctors never had it so good.

Heiresses

STUDENT nurses at Lutheran Hospital, Fort Wayne, Ind., opened their newspapers one morning last summer and discovered that they were heiresses. A man named Harley J. Davis, who had been a patient in the hospital before he died, had established an unusual trust fund for Lutheran students. Under its terms, every student in the school got $150 right away. In addition, future students will get $100 for every year of training they complete at the hospital.

Mr. Davis was a retired streetcar motorman, of all things, who made his money by the unheard of method of frugal living and saving. Student nurses took good care of him when he was ill, he told his bankers when he established the $125,000 trust. "It's a shame they aren't paid," he said. Hospital officials estimated the principal sum would last 15 or 20 years. By that time, they hope, the nursing shortage may have improved some.

Vote!

FOR more than 2000 years, western man's urge for freedom and brotherhood has been struggling with his lingering mistrust of majority rule. The ancient Greeks and Romans built their democracies on foundations of intolerable slavery. Centuries later, Thomas Aquinas insisted that all men should have a share in government, but it was long after Aquinas before the great modern advocates of liberty, Milton and Locke, won a limited measure of political freedom for the people.

It remained for our own philosophers, notably Thomas Jefferson, to make the British concept of representative government fit the American idea that all men are created equal, and then to add the element that makes the republic work—the theory of the representative's periodical accountability to his constituency, as argued by Madison in "The Federalist." If democracy really means the people rule themselves, it is not enough for them to elect their officials; they must also demand an accounting, at stated intervals, of how well the officials have discharged their responsibilities.

One such interval terminates this November 4. Plainly, the vital element of accountability is meaningless if only a fraction of the people demand the accounting. The long struggle for political freedom may yet be lost, if citizens fail to use it. On page 232 of this magazine is a poster, prepared by the Advertising Council, urging Americans to exercise their hard-won freedom—to register and vote. This much, certainly, we owe to the philosophers, from Aristotle to Jefferson, who struggled to give us the liberty we enjoy. To hospitals that want to do their share by urging their staffs and employes not to default freedom, The MODERN HOSPITAL will send copies of this poster, without charge, for bulletin board use. Write and tell us how many copies you can use.

DR. ROURKE AND DR. MAC EACHERN STRETCH THE HOSPITAL DOLLAR AS MR. SMITH LOOKS ON (P. 57).

The Convention Digest — 1952

Theme

PHILADELPHIA.—The President of the United States shared top billing with a gleam in George Bugbee's eye at the 54th annual convention of the American Hospital Association here last month. When the convention closed, it was plain that the gleam would outlast the President: Delegates had approved the Bugbee vision of a far-flung Institute of Hospital Affairs, their misgivings about money and details subdued by the bright shape of things to come in hospital research and education.

Both the President and the Institute were presented to the convention with dazzling displays of razzmatazz. The President had his secret service, a brass band and a roomful of admirals and generals; the Institute had a stage manager, a walkie-talkie microphone and a flannelboard, or Madison Avenue improvement on the old-fashioned blackboard. The President had detractors in the back of the room, and so did the Institute. The President's detractors were left with their teeth at half-mast when the federal hospital luncheon at which he spoke turned out to be a smashing success, but, as it turned out, it wasn't the slick, dim-houselights-up-spots technic that put the Institute across in the end; it was hard reasoning about the association and its future by some of its best friends—mostly officers, trustees and delegates.

With registration reaching for 11,000—an all-time record by a big margin (last year's record registration was 8500)—the show had to be good, and it was. The general sessions pulled near-capacity crowds of 1500 or more and held them, for the most part, in an auditorium that was sweltering hot and maliciously designed to obstruct the view of all but a few customers who sat down in front, where it was hottest. Philadelphia steamed all week, and transportation to and from the convention hall was, to put the nicest possible construction on it, uncertain. At times there wasn't any. Those were the times it rained.

In spite of these ferocious handicaps, the exhibits and meetings played

to packed houses most of the time. First-class programming brought in capable people with something to say, then added the thing that had frequently been missing before: They were told how to say it. Instead of being unleashed to ply the convention at will with formal papers or diffuse spontaneity, speakers at most of the general sessions were coached and timed, and then led, through panel discussions that had the three essential elements named in Aristotle's "Rhetoric": a beginning, a middle, and an end.

As the 54th convention is replayed in years to come, however, these new program methods will be heard as grace notes. The main theme will emerge as one of hope and courage, of vision transformed into action by men and women who were thinking seriously about their tasks in our society and their obligation to help build a better world. It will sound good.

Tony's Day

Like parents who don't fully realize that their boy has become a man until they see him away from home, hospital administrators gained a new awareness of the stature of their association on Tuesday, September 16, when the convention spent the day in the bright light of national publicity. They had lunch with the President of the United States, and after dinner they were on the air with America's Town Meeting. Unquestionably, this day's work will make it a little easier forevermore for hospitals to get a public hearing for their problems and accomplishments; the public understands, as St. John did, that "He that loveth the truth cometh to the light."

It was a big day for everybody, but for A.H.A. President Anthony J. J. Rourke it was staggering. Dr. Rourke started the day by riding from the station to the convention hall with President Truman and ended it by carrying the hospital end of the pole at the Town Meeting, with Professor Eli Ginzberg of Columbia University playing the villain. During the day Dr. Rourke attended half a dozen meetings, toured the exhibition hall, entertained the President, shook hands with a few thousand people and made a speech at the federal luncheon, which turned out a capacity crowd of 2500 to see the show and hear the President.

At any other time, or from any other speaker, the President's speech

President Truman waves to his audience at the Federal Hospital Council Luncheon.

might have been accepted at its advertised "nonpolitical" value. Except for one crack at "pullbacks" who want to stand still with things as they are in the health field, the speech itself was mild enough—a review of the growth of federal medical services and a look at some of the broad health problems that remain to be solved. In fact, many hospital administrators in the audience, yielding to no doctors in their abhorrence of socialized medicine, thought it was a pretty good talk. But the "pullback" crack pulled the cork. Newspapers promptly pasted the label on General Eisenhower, from whose recent speech against compulsory health insurance the President quoted a few words, and immediately the wires started to burn with indignant replies. In a matter of hours, it was apparent that "pullback" would become a celebrated campaign cliché, possibly ranking with Roosevelt's "forgotten man." Technicians on both sides moved in eagerly, swinging the term with two hands, like an ax, and giving the American Hospital Association a firm, if somewhat uncomfortable, place in the nation's political history.

CONVENTION TALKS BACK

Some of the earliest replies came from within the convention itself. Talking shortly after the President left the hall, Curtis W. McGraw, president of McGraw-Hill Publishing Company and Princeton Hospital, departed from the text he had prepared for the session on trustee relations to say pointedly:

"I make these suggestions [for free hospital development without government jurisdiction] as nonpolitically as any of our Washington guests who seem to feel otherwise. The pullbacks mentioned this noon do *not* want to stand still." The convention applauded —plainly, in this case, expressing its approval of the statement rather than simply its respect for the occasion.

Another reply came from James E. Stuart, chairman of the Blue Cross commission, who left the Truman luncheon shooting off Blue Cross statistics like a Roman candle. "We favor no pullbacks," Stuart told reporters. "But those who march down the road toward better health cannot achieve the goal wearing the handcuffs of compulsion," he added, producing the convention's best example of the three dimensional, or revolving, metaphor.

For most convention-goers, the occasion of the President's visit was more exciting than the content of his speech. Riding from the station with Dr. Rourke, Mayor Joseph Clark of Philadelphia, Governor John Fine of Pennsylvania, and Dr. Charles F. Wilinsky, the President arrived at a back entrance to the convention hall and came in through a huge, gloomy receiving room which got a careful inspection from secret service men moving in ahead of the presidential party. The packing cases in the receiving room proved as harmless to presidential safety as the Republicans inside the convention hall, and the party came in and proceeded briskly with an accompaniment of restrained applause, to the A.H.A. booth at the center of the hall, where Assistant Director Maurice Norby registered the President as a guest and pinned a convention badge on him. Preceded by secret service men and Philadelphia police who cleared the way of curious onlookers, the President and his hosts marched down the main aisle of exhibits to the display of the federal medical services, where they stopped and looked things over. At the last minute, arrangements had been made to have the President's chest x-rayed at the mobile unit operated during the convention by the Public Health Service, but this didn't come off. "He went by here so fast we scarcely saw him," said a disappointed attendant at the mobile unit.

While the vast arena upstairs was filling up with guests, the President relaxed in a back room, taking a drink and visiting informally with A.H.A. and federal hospital brass. When Dr. Rourke showed him one of the rubber dollars handed out at the "Stretching Your Hospital Dollar" sessions, the

President said quickly, "That's what they call a Truman dollar!"

Under the direction of Toastmaster Fred A. McNamara, chief of the hospital division, Bureau of the Budget, the luncheon program followed the usual pattern of introductions and remarks, then veered sharply off course when President Truman got up out of turn to present a citation from federal hospital executives to Mr. McNamara in appreciation of his work in bringing federal hospital administrators from the various services together, developing the interagency institute for federal administrators, and arranging the federal hospital luncheons. Then came Dr. Rourke with official greetings and an adroit touch about the "nonpartisan nature of disease" and, finally, President Truman and what will always be known as "the pullback speech at Philadelphia."

TOWN MEETING

At the town meeting on hospital costs, which went on the air from the packed ballroom of the Benjamin Franklin Hotel Tuesday evening, Dr. Rourke presented evidence that hospitals can't be classified as pullbacks. Answering questions posed by Professor Ginzberg and members of the audience, Dr. Rourke said hospital people were constantly concerned about maintaining standards of care without adding unnecessary cost. He mentioned the programs of the American Hospital Association and the Commission on Financing Hospital Care as examples of forward-looking effort to find better answers. But Dr. Rourke insisted there must be no compromising of standards. "Any desire to reduce the amount of money spent on hospital care is unwise," he declared in reply to a question from the floor. "We need to spend more, not less! We could give you half care, but who wants to be half sick?"

Opening the discussion, Professor Ginzberg had charged that hospitals waste money by not putting the right patient in the right hospital, by not utilizing hospital facilities fully, and by permitting insured patients to "come early and stay too long." He referred particularly to the use of general hospitals for chronic patients who could be cared for more economically in nursing homes or in home care programs sponsored by hospitals, he said. Acknowledging the need for study of such problems, which he said was constantly going on, Dr. Rourke denied

Ritz E. Heerman of California Hospital, Los Angeles, is A.H.A. president-elect.

that special institutions for special types of care offered any economies. "Special hospitals would be a step backward," he stated. "The medical profession has found that integrated service is more satisfactory."

Doctors are as interested as hospitals are in reducing the costs of medical care, Dr. Rourke said, answering a question on this point. He cited improved staff organization and studies of medical-hospital relations as evidence of the desire to meet the challenge of increasing expense resulting from the growing complexity of medical science.

In answer to Professor Ginzberg's claim that many hospital services are shut down from Friday afternoon to Monday morning, Dr. Rourke pointed out that hospitals have a dual trust—they must serve sick people, but they must also meet the human needs of their own personnel. He described how working conditions, especially on nursing services, had been improved and working hours shortened in recent years, explaining that in order to meet the needs of employes it was necessary to cut down week-end service except in emergencies. "There is no solution to this problem yet," he said. "That's why we come here to discuss these things." As the town meeting—and the big day—drew to a close, there was no question, at least, about the need for shorter working hours for Dr. Rourke.

Coats and Hats

Coats came off when the association's house of delegates went to work in Philadelphia's stifling heat on Sunday morning preceding the convention, and hats were off—to the staff and trustess—when the delegates closed their final meeting Wednesday night. From the beginning, it was clear that a question would be raised about the trustees' bold plan to establish a university-based center of continuation study and research in hospital administration and related fields—the Institute of Hospital Affairs, a project that was either a stroke of genius or a pipedream, depending on who was talking.

Actually, the delegates knew it was neither. They saw the plan instead as a carefully developed opportunity to assure the association's progress toward ever greater usefulness to its member hospitals and their patients, but many of them seriously doubted the wisdom of going forward with approval of the Institute "in principle," as the trustees asked, without knowing definitely where the money was coming from and without knowing more of the details. Some feared a possible dues increase if outside financial support should be lacking entirely or should fail later on. As Trustee Frank Bradley summed them up in the later stages of the discussion, there were 11 questions that were being raised about the proposal.

Published initially in the association's journal *Hospitals* several weeks ago, the proposal was presented formally to the house when Executive Director George Bugbee read a 20 minute report describing the Institute in detail and concluding with the trustees' recommendation for its establishment—with hopes of a $5,000,000 foundation grant (half for a building that would house the association, the Institute and possibly others, half for five years of operation), but establishment, at worst, as soon as alternative plans for financing could be worked out.

As soon as discussion was called for, Delegate Guy Clark of Cleveland asked for the floor to read a prepared statement opposing approval of the proposal now. His point: A program of such magnitude should be referred to state associations for study and discussion, then brought back to the house, if the majority of states approved, next year. Delay, Clark said, "would not greatly affect the hoped for result."

Soon other questions were spilling into the aisles. What would be the precise relationship between the Institute and the association? Where would the university fit in? Where would it be located? What were the chances, really, of getting the foundation grant? What about other support?

Officers and trustees recited the answers: There would be a separate Institute board and staff, and a scientific committee from the university faculty; these groups would be responsible for policies and programs; the association staff would be advisory to the Institute. No university had been named, but it seemed likely that the location would be Chicago. Support from one foundation would not preclude aid from others. Same with universities.

These and other questions got the full treatment from the high-powered team of Rourke-Crosby-Bachmeyer that presented the Institute proposal to the membership at the opening general session of the convention Monday afternoon. They spelled it out, up and down and sideways, relating the concept to the nation's needs for health services and the program to the hospital's need for guidance.

Back in the house Wednesday evening, the Clark resolution was read again, and its approval was moved and seconded. Then, like the Hound of Heaven, "with unperturbed pace, deliberate speed, majestic instancy," board members got up, one after another, to mow down all the objections that had been raised. The finishing touch was delivered by the Rev. Donald A. McGowan, who dealt with the suggestion that action should be delayed. "If we wait until we dispel every last fleecy cloud of doubt," Father McGowan told the house, "we'll be like the fellow and his girl who waited until they could afford to get married. They did—and they both went down the aisle in wheelchairs. . . . We've been dropping pebbles into the water and admiring the ripples they cause. Now we have a chance to drop the Rock of Gibraltar, creating waves that will touch every shoreline of health care!"

That wrapped it up.

In dispatching its other business, extensive and complex as it is, the house struck only one snag—accreditation of nursing schools. Presenting his report as chairman of the council on professional practice, Dr. Albert W. Snoke of New Haven indicated that the council had carefully considered the position of the small hospital schools that were left on the ground when the accreditation balloon went up in the air last summer. Nevertheless, he reported, the council's feeling was that we must have standards, and when standards are applied, some one is certain to get hurt. Hospitals are adequately, if not abundantly, represented in the accreditation picture today, Dr. Snoke said.

The discussion, which ranged over both delegates' sessions, uncovered substantial doubts that this is the case. Expressing embarrassment at being cast in the rôle of dissenter for the second straight year, Stuart Hummel of Wisconsin, who led the fight on federal aid to nursing education in the house last year, once again laid down some plain language, warning hospitals that they were letting an outside group determine the rules of the game. "It is high time we did something for the 275 hospitals in our association [those with schools not accredited] which are looking to us for leadership. It should be the responsibility of the American Hospital Association to determine the standards by which we care for our patients."

In the end, the house considered an amendment to the report calling attention to the possible effects of accreditation on nursing supply, reaffirming the principle of accreditation as a means of improving nursing service, and recommending review by the A.H.A. of the National Accrediting Service "to determine if it is the most effective organization for implementing accreditation of schools, and to assure that such organization has adequate and active representation of hospital administrators and/or hospital trustees in the policymaking body."

"The resolution is a waste of words," Hummel argued. "Pass it, and you'll be right where you were when you started." They passed it, and he quickly introduced another amendment to the council report, recommending appointment of a committee to study means and methods of developing an accrediting program, within the association itself, for the training of personnel caring for patients in hospitals. Executing a neat *glissade*, the house passed that one, too. Association policy on accreditation was in a fluid state, but it was hard to tell whether that was good or bad.

As the convention did at its opening session, the house of delegates heard and approved President-Elect Edwin L. Crosby's report on the Joint Commission on Accreditation of Hospitals. The commission is expected to take over from the American College of Surgeons by the end of the year. In addition to association council reports, delegates also listened to accounts of the activities of the women's auxiliary committee and the Blue Cross commission, and heard Dr. Paul Barton of the Health Resources Advisory Committee warn that Priority I and II physicians now serving as interns and residents will all be in class 1-A, subject to immediate call, by March 1, 1953. Without any questions or comments, the house took the word of Ross Porter, chairman of the council on government relations, that a change was coming in association policy on care of veterans. At Mr. Porter's request, this section of the report was not submitted for approval.

As the final meeting of the house of delegates drew wearily toward 11 o'clock, after hours of discussion and three days of convention mileage and heat, members of the house came up smiling on two occasions when President Rourke introduced distinguished guests. One was brand-new President-Elect Ritz E. Heerman of Los Angeles, and the other was Johnny Rourke of New York, the president's son. They both looked good to the house.

Trustees

In a meeting punctuated by lively exchanges between the panel and the audience and microphones that emitted unexpected whistles and occasional catcalls, trustees from half a dozen eastern hospitals held a mock board meeting with Administrator Richard Vanderwarker of Memorial Hospital, Anytown, U.S.A. (on leave from New York's Memorial Center for Cancer and Allied Diseases), then answered questions from the floor about their deliberations and decisions. The questions were directed to board members, sometimes with considerable top-spin, by Moderator Raymond P. Sloan, editorial director of The MODERN HOSPITAL and a member of the board of Memorial Center in New York City.

The session began with a sober discussion of trustee responsibilities by Curtis W. McGraw, president of Princeton Hospital, Princeton, N.J., who got the audience on his side right away by declaring that if trustees gave

their full time to the job "well trained and efficient administrators would either go crazy or have little time to perform their duties." Mr. McGraw also cast his vote for small (15 member) boards, slow turnover of members, trained administrators ("The time has long since passed when a board member, a retired businessman, or a committee can function effectively as the chief executive officer"), complete authority for the administrator, board responsibility for quality of patient care, hospital consultants, patient opinion surveys, modern management methods, integration of hospital facilities, free enterprise, and a firm answer for hospital critics. Hospitals are moving in the right direction, he concluded, but the pace should be stepped up.

When Mr. McGraw finished, the board meeting got under way. The administrator reported that a study made by the personnel policies committee of the hospital had revealed that doctors and nurses weren't getting along together, a circumstance that evoked a sympathetic titter from the audience. However, Mr. Vanderwarker added, things were looking up; a personnel manager had been employed, some meetings were being held with department heads, and attitudes were improving. Board member Reginald Coombe (Memorial Center, New York City) wanted to know if trustees on the committee were getting mixed up in administrative functions. Mr. Vanderwarker admitted that this possibility had made him nervous in the beginning, but it hadn't worked out that way. The board dealt with policy and left practice to him, he said, as heads nodded all around the room.

From here on there was less sweetness and light. Mrs. A. E. Pinanski (in Boston she's on hospital boards right and left, in addition to being chairman of the A.H.A. committee on hospital auxiliaries) read a letter from the chairman of the auxiliary to the president of the board suggesting some kind of fund-raising gismo; in the discussion that followed, she suggested that the auxiliary should be represented on the board so the ladies would know what the boys in the back room were thinking.

This caused trouble. President H. Irving Pratt (also president of North Country Community Hospital at Glen Cove, Long Island) took a dim view of what he called the "nibbling approach" to fund raising. Member

Homer A. Vilas Jr. (Mountainside Hospital, Montclair, N.J.) felt that money in any quantity should be welcome but thought the board should keep posted on what the women were doing and have authority to approve or disapprove their projects in advance. Somebody else wanted to know why the letter was addressed to the president instead of the administrator, and Mrs. Pinanski wanted to know why not?

After the board meeting closed there was further discussion on this last point, and divided opinion as to whether the shortest distance from the auxiliary to the board is a straight line through the administrator's schizophrenia. Mr. Sloan said absolutely, and Mrs. Pinanski said absolutely not, or at least not necessarily. There was disagreement, too, about auxiliary representation on the board, but it was agreed that some means must be found to keep each group informed about the other's sins.

On this happy note, the discussion moved along to consider an application for staff membership from a doctor who was obviously, on the face of it, a professional genius and a copper-riveted stinker. These things happen sometimes, board members reminded one another. The application had come along by the scenic route (staff credentials committee to staff to joint conference committee to board), Mrs. John Brelsford (Samaritan Hospital, Troy, N.Y.) informed the meeting. To apprehensive board members who wanted to take another look before passing on the application, she replied that the conference committee had already investigated reports that the applicant, as a member of the courtesy staff, had had trouble with the obstetrical supervisor, or vice versa. "I'd rather lose a doctor than an O.B. supervisor!" the administrator groaned. When the laughter died down, he added that with the promised cooperation of the chief, he was sure the doctor would become, as the conference committee had euphemistically expressed it, "a cooperative member of the hospital family." When it came to a vote, however, the board decided to consider the matter further and put the decision off until its next meeting.

The next question was money. Treasurer Philip B. Kunhardt (actually President Kunhardt of Morristown Memorial Hospital, Morristown, N.J.) reported gloomily that the hospital's financial position was becoming more and more unfavorable, a statement that caused laughter in the audience, but with overtones of hysteria. Losses were going up and rates should be raised, Mr. Kunhardt declared. Mr. Vanderwarker explained that ward and semi-private rates were actually below costs —a situation that required study and adjustment. Some members favored an across-the-board increase on room rates; others wanted individual charges adjusted as cost facts demanded. Mrs. Pinanski suggested that if the hospital just had a gift shop, as some of the ladies had been suggesting, maybe they wouldn't have to raise rates after all. The men were patient and polite but were obviously thinking about the many differences between a gift shop and a gold mine. Eventually, everybody got to the point: Rates are a public concern; rate decisions should be made only after considering reliable public relations information and advice; public relations should be a board job but, please, not until next month!

At this point, Anytown gave way to New York, Boston and New Jersey, and, in reply to questions from the floor, the panel members started telling about their own hospitals. They all had real joint conference committees, it turned out, and they all worked good, too. A hassle developed on a question of whether department heads should attend board meetings, and excited administrators in the audience jumped up to attack or defend. Verdict: Department heads may be called in as their competencies may be needed in reviewing special problems, but take this remedy only as needed, not as regular treatment. Mr. Sloan and Mr. McGraw stood firmly against doctors on the board, but Mr. Vilas has the president of the medical staff on his board and likes it that way. Dr. Fred Carter of Cleveland, from the floor: There isn't any one right answer for everybody; it depends on the people involved in each case.

The bell rang for the end of the meeting along in here someplace, but the discussion kept going, at the request of the audience, for another 10 or 15 minutes.

Drama on the Delaware

If a bad beginning makes a good ending, the success of the cruise of the *Delaware Belle* on Monday evening was assured from the start. The Philadelphia weatherman, in churlish mood, turned loose a driving rainstorm promptly at 5 o'clock. The sailing was delayed for an hour to permit ticket-holders to fight their way from the convention hall to the water front. And, to the intense embarrassment of the host committee, when she finally got under way, the *Delaware Belle* was missing her most important passenger —Rudy Vallee, the star of the show. In spite of it all, 2000 or more (it seemed like a lot more) determined merrymakers dripped aboard, ready for an evening of fun and frolic.

Disregarding the signs which read "Passengers Must Not Open or Close Windows," the passengers promptly opened as many as they could pry up —preferring the possibility of pneumonia to the certainty of suffocation. They danced and they ate, they drank coffee, which was miraculously good and plentiful, and they waited hopefully for the promised floor show. As the weatherman repented of his misdeeds, more and more passengers drifted to the upper decks to watch the lights of the shoreline, breathe the fragrance of the oil refineries, and indulge in a little close harmony. And still they waited for the floor show.

Tommy Tucker's orchestra and singers performed valiantly and, finally, around 9 o'clock, announcement was made that the entertainment would begin. It did—but without Mr. Vallee. Tommy, with the resourcefulness of his calling, enlisted four members of the audience to come to the microphone and "sing for their supper," the audience to be the judge of which was most deserving of a good meal. Hands-down winner of the contest was James Daniel of Columbia Hospital, Columbia, S.C, who gave out with a spirited rendition, with hiccups, of "Show Me the Way to Go Home." And still no Mr. Vallee.

Rumor and speculation were rife, but nobody had the answer to the mystery of the missing entertainer. It was solved in dramatic fashion just as the ship was about to return to port. With an immense grinding of engines, the *Delaware Belle* suddenly shivered to a stop as a small boat, its lights signaling madly, skirmished around her and, after a few maneuvers, drew along side. As a policeman stationed on the *Delaware Belle* ran to the side to warn the intruder off, a flaming orange head emerged from the depths of the little navy cutter, followed by the scarlet clad shoulders of the errant star. Muttering "Well, better late than never," the policeman hauled a grinning, somewhat sheepish Rudy aboard, depositing him at the feet of passengers lined up waiting to disembark. Rudy had missed the boat, hunted up and down river until he found it, and talked the cutter crew into taking him out to it. It was as simple as that.

There was a concerted rush for the upper deck where the orchestra was still playing, a little confusion while the floor was cleared and chairs were shuffled about, and then the show was on. It was a good show. The Vallee voice is no better than it ever was, but the charm is still in good working order. He kidded everything and everybody, including himself and the audience; played his saxophone, and evoked nostalgic sighs from the Over-Forties in the group with the "Whiffenpoof Song," the "Maine Stein Song," and even the regrettable "Vagabond Lover." As a finale, he made the audience join him in the gay little French-Canadian song "Allouette."

To one small group of cruisers, wending their way homeward, was given a final, unexpected lagniappe to top off a strenuous but amusing evening. Inspired by the general merriment, Emanuel Faucon, visiting French hospital dignitary, burst forth into song. In a delightful voice, he warbled Allouette—as it should be sung—and, beaming happily, continued to sing in French all the way back to the Ben Franklin. Mr. Vallee should move over.

Nurse Stretching

"We can't say we have a personnel shortage," Ruth I. Gillan, nurse consultant of the Division of Nursing Resources, Public Health Service, told a dollar-stretching convention session, "until we utilize our personnel fully. Utilization studies may show that we can actually reduce the total number of nursing personnel needed. They may show that we can use cheaper nonprofessional personnel."

Miss Gillan discussed possible hospital economy through studies of head nurse activities, since "the head nurse is the human switchboard of her unit."

J. T. Gates, director of the Hospital Methods Research Council of Cleveland, reported his Cleveland studies on applying the methods of industry to hospitals.

"In many respects, hospitals have the same problems as industry has—good performance of small repetitive tasks that influence the cost of the final product. Nothing has been done in hospitals because no such competitive pressure has existed. He described a system to eliminate handwriting operations in nursing stations.

Human Relations Day

The aspirin approach to personnel troubles is all wrong. Surgery may be the answer.

The doctors of human relations held a consultation before the public on Wednesday, and between and behind every pillar in Studio A an enthralled audience watched and listened. Television is rarely that good.

Picture, first of all, a 45 foot screen on which appeared successive panels of experts, each life size. In front of the huddled experts stood a hedge of microphones; the moderator wore a mike around his neck, tuba-like. Angled down upon these enthroned educators, industrialists and human relations specialists were spot lights. Sometimes they, and the audience, witnessed dramatic episodes; sometimes they heard transcribed case histories of sick departments. The audience participated by sliding into a bullpen; too, there was a mythical $2600 jackpot, payable to Memorial Hospital and donated by the women's auxiliary—who else?

Tuesday morning brought a brief curtain raiser to Human Relations Day observances. At that time the Cornell crowd briefed the audience on the A.H.A.'s study commission on human relations, with George Bugbee emceeing. The study has started down in the kitchen with a field worker grating cheese along with the cook and is proceeding onward and upward for two years in various sized hospitals; it will culminate in a factual report and a manual of technics.

Wednesday's double bill variety shows might have been called "I Don't Love Lucy," for personality conflicts, interdepartmental friction, and charges of general cussedness and laziness were the complaints considered. Although these situations looked hopeless to the persons involved, the "doctors" managed to agree on the diagnosis in each case and to recommend suitable ther-

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Mr. Smith Goes To Convention

A picture story of the A.H.A. convention in Philadelphia, September 15 to 18, 1952

1. Last night Ernest Smith was just another Rough Rider on the Pennsy R.R. This morning our hero happily jack-knifes into a Philadelphia taxi, followed by Marshall Shaffer, chief architect, U.S.P.H.S., and Robert Jones, assistant administrator of Columbia Hospital in Milwaukee.

2. Treading softly behind the mobile faced, exquisitely tailored Dr. Basil C. MacLean of Rochester, N.Y., Ernie Smith crashes The Modern Hospital editorial board party on Saturday evening, a maneuver he can't repeat until he gains Administrative Fame Through Service.

3. Even the ambitious Mr. Smith can't crash the convocation procession of the College on Sunday, but as he sees President E. I. Erickson, the chaplain, and Honorary Fellow Fred A. McNamara queuing up he vows that some day he too will rank with the nobles of the hospital realm.

4. Philadelphia's Sunday blue laws may spell boredom to some folk but to our Mr. Smith they spell freedom—American freedom. He's boning up on American history, starting, as any student must, with Independence Hall.

5. Regarding himself as a citizen of the world as well as of the nation, Mr. Smith, visiting the Cradle of Liberty, seeks out a convention visitor from afar. Here he meets Executive Secretary Emanuel J. Faucon of the Hospital Federation of France.

6. Smith's is a strictly nonbanquet budget, but he can peek behind the scenes at the banquet where the speaker, Judge Harold B. Wells of Bordentown, N.J., gets acquainted with A.C.H.A. President Erickson.

7. Registration Clerk Edna Dunphy pins on Ernie his first hospital convention badge. Claiming similar personal attention comes Lt. Col. Harry Deil, USAF (MSC) of March Air Force Base, Riverside, Calif.

8. Ernie fights shy of designing women but he's a pushover for designing men —architects, we mean. Here he gets a briefing from Mario Bianculli of Chattanooga, Tenn., and Edwin B. Morris, Public Health Service architect.

9. Elbowing his way through the exhibit crowds, Ernie stands aside while Hospital Industries Association leaders talk things over. They are William Smith, new director; Charles Pain, president, and Edgerton Hart, retiring director.

10. At his first hospital convention, Ernie finds the technical exhibits more educational than the educational exhibits. Here he tries out the new light monitor that signals if a patient moves violently or tries to get out of bed.

11. There is not a cough in a carload of Ernie Smiths but he can never pass up a free chest x-ray. Here Henry Hamil of the U.S. Public Health Service positions Smith for an examination.

12. Ernie dimly senses it but all the oldsters recognized it: the bright new faces in the hospital field. On either side of Ernie are Robert F. Tuveson, assistant administrator, Middlesex Hospital, Middletown, Conn., and Robert B. Ogrean, administrative assistant at Grace-New Haven Hospital, New Haven, Conn.

13. Young Smith is the chairman's delight; he's at all meetings on time. Other early birds are Donald W. Cordes, Iowa Methodist Hospital, Des Moines; Marion B. Dennis, executive secretary, Iowa Hospital Association; Smith, and Richard R. Merker, Hand Memorial Hospital, Shenandoah, Iowa.

14. Smith seldom feels "the importance of being Ernest" as much as when, the only man in sight, he slips in to the Hospital Auxiliaries Conference. Here he meets Esther Simpson, director of volunteers at Philadelphia General, and her counterpart at the University of Chicago Clinics, Elizabeth E. Borstrom.

15. Smith proves himself a convention amateur by taking a seat just back of the Sisters of St. Vincent de Paul. So guileless are Sr. Justina of St. Mary's, Evansville, and Sr. Roberta of St. Vincent's, Los Angeles, that everyone sees through to the very warm hearts inside them but nobody sees around them.

16. Uniforms are everywhere but Ernie is a little puzzled to find men like Maj. Gen. George F. Armstrong in civvies. The army's surgeon general is talking to C. C. Hillman of Jackson Memorial Hospital, Miami, Fla.

17. An American convention without a coke bar or a snack bar is unthinkable, for meeting rooms grow warm and Ernie Smith and all the Smiths grow drowsy. So it's out into the corridor for a quick pick-me-up.

18. Ralph J. and Virginia Hromadka of Santa Monica, Calif., Smith and some 2000 others board the *Delaware Belle* on Monday evening, rain or no rain.

19. Be Kind to the Feet Corner in the A.H.A. booth in Convention Hall provides needed relaxation, reading and conversation on a superheated afternoon.

20. Hospital bull session with John G. Steinle, U.S.P.H.S.; Nick J. Karabaich, resident administrator, Springfield (Mass.) Hospital; Architect Victor J. Probst of Austin, Tex.; Robert Harth Jr., administrative resident, Freedman's Hospital, Washington, and Bank I. Paul, administrative resident, V.A. Hospital, Brooklyn, N.Y. Smith is playing the center position.

21. Standing with the photographer facing a section of the giant-pillared Room A, scene of the general sessions, Ernie Smith experiences the dry tongue and sweaty hands that speakers feel as they look down upon a rapidly filling house. They wouldn't like it if most chairs were empty, Ernie reasons, and with that his stagefright symptoms disappear.

22. "See you in San Francisco next year, maybe," cry two of Ernie's new friends as they shake hands in parting. "That'll be up to my first board of trustees," Ernie answers. "From all I've heard here this week," he tells Donald W. Rosenberger of Maine General and Pearl R. Fisher of Thayer Hospital, Waterville, Me., "I'm set to do things—true things, human things, God-inspired things." (The Ernest Smith in this picture story of the convention is William Mylchreest, an administrative resident at Grace Hospital, Detroit, and a graduate of the hospital administration program at Columbia University.)

THE END

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apy leading toward a possible cure, provided the "patients" were willing to cooperate.

It was Malcolm Knowles of the Adult Education Association of the United States who attacked the aspirin approach on the ground that it treats merely the symptoms of a disorder. The causal approach, he said, and all the others concurred, is the only sensible attack on human behavior problems. The experts did not all agree on method—of which they cited many and fancy—but they did contend that "rôle flexibility" is important; to this the audience agreed after the term was interpreted. (You can't apply the same technic in every situation but must try to come up with a method to fit the case—that's rôle flexibility.)

"The primary responsibility in hospital human relations rests with the administrator," Dr. Knowles declared. "A satisfactory working environment is based on (1) respect for personality; (2) individual participation in making decisions by those who are affected by these decisions; (3) the basing of all supervisory decisions on facts, and (4) the practice of sharing the fruits as well as the responsibilities of the common enterprise."

Gordon L. Lippitt of the National Training Laboratory in Human Relations insisted that "leaders are made, not born" and that all of us can develop the skills of leadership if we are interested enough to work hard at it.

As to how a hospital administrator can develop leadership qualities in human relations, Mr. Lippitt is of the opinion that reading books and holding staff conferences are in themselves not enough. He advises the administrator's getting into a "sharing situation" by leaving his hospital desk and sitting in on an institute for a short period. Such intensive experience in practicing human relations skills should be repeated at intervals, he believes.

"Crisis leadership" is the type to get away from, the authorities agreed. The hospital administrator must develop skilled leadership in himself and his supervisors so that they can anticipate interdepartmental and departmental friction before it develops.

The really capable administrator will approach his staff with the certainty that all the people have the best interests of the hospital at heart. If he takes this for granted, the chances are he will have no real problem.

The autocrat as an administrator of the hospital, nursing school or any department went out of date 20 years ago, it was said. If the administrator or supervisor is autocratic, he gets a quicker decision but implementing that decision will take longer. If he is democratic it will take longer to arrive at a decision but its implementation will be short. The over-all elapsed time is actually shorter through use of the democratic approach.

Dollars and Doctors

The girl at the girdle counter is more of an expert on the two-way stretch than are the hospital administrator and the staff doctor in combination. In the hospital dollar stretching act, there isn't a great deal of give on the doctor's side.

Dr. Clement C. Clay, administrator of the Hospital Center at Orange, N.J., polled 180 doctors for suggestions to improve efficiency and reduce costs and he garnered the grand total of nine replies. However, after pep talks, staff letters and other shock therapy, Dr. Clay reported that some of the staff are really cogitating about hospital problems now.

The continuing study being made by the council on professional practice of the American Hospital Association was described by the council's secretary, Dr. Charles W. Letourneau. "Hospitals can affect to a certain extent the manner in which diagnosis and prescription are made by making the physician aware of the impact that his professional acts will have on the economic welfare of the patient."

Officers Named

Ritz E. Heerman, superintendent of California Hospital, Los Angeles, was named president-elect of the A.H.A. Dr. Edwin L. Crosby, executive director of the Joint Commission on Accreditation of Hospitals, moved into the president's chair at the convention's banquet on Thursday evening.

Dr. Arthur C. Bachmeyer, director emeritus of the University of Chicago Clinics, was reelected treasurer.

The three new trustees are: Dr. J. Gilbert Turner, executive director of Royal Victoria Hospital, Montreal; Robert S. Hudgens, administrator, Lynchburg General Hospital, Lynchburg, Va., and B. Tol Terrell, administrator of Shannon West Texas Memorial Hospital, San Angelo, Tex.

New delegates at large are: Dr. Wilmar M. Allen of Hartford, Conn.; Dr. Harold E. Baird of Regina, Sask.; Rt. Rev. Msgr. George Lewis Smith of Aiken, S.C., and Harry C. Wheeler of Billings, Mont.

Design in the Morning

A heat filled room in which nobody drowsed accommodated the dynamic session on design on Thursday morning. Seats were hard to locate but ideas soared in the air like flying saucers.

Dr. Carl W. Walter, the sharp witted surgeon from Peter Bent Brigham Hospital, Boston, begged the boys to take the industrial approach to hospital design. Most of the planning must be done through a succession of management decisions long before "the architect dirties the paper with his pencil."

Prototype plans, visits to 85 hospitals, idea exchanges in convention meeting rooms—these mean little in his opinion. All the answers must be found on the local community level. This view was sharply challenged from the floor, and in the ensuing exchange of pleasantries Dr. Walter was heard to mutter that "most hospital patients would get well at home just as quickly."

Saving time through well planned hospital communications interested Robert W. Cutler of Skidmore, Owings and Merrill. He held that vertical communication by elevators is now almost an exact science, but that no comparable technical advance has been made in the dumb-waiter and tray conveyor systems, both of which eat up too much space. Great imagination has been shown in the development of electronic paging systems, with radio paging being tooled for the hospitals of tomorrow. Mr. Cutler figuratively wrapped a towel around his head to predict that one day the nurse at her station may be observing the patient and listening to his breathing over TV.

"Working smarter but not necessarily harder" is the goal of work simplification practices, said Harold E. Smalley of the Motion and Time Study Laboratory, University of Connecticut. He wants the industrial engineer to have a place on the hospital planning team that precedes the layout of areas by the architect. Easier, quicker and less fatiguing methods will offset the labor shortage in hospitals, if they will but accept the practices long used in industry.

One of the many arguments that

enlivened this session was over the proper location of the nurses' station. Some argued that the nurses should not be near the elevators but near the patients and that clerks should control the visitors and nonnursing activities on the floors. Dr. Harvey Agnew surmised that after visiting hours the clerks would be hard at work giving themselves manicures. The ward manager system, as being used at Memorial Hospital, New York, was suggested by someone as an alternative.

Another question Consultant Agnew raised was the long distances now traveled from wards to x-ray rooms and other adjunct services. The time thus wasted might call for minor x-ray facilities nearer at hand.

Again posing as a seer, Mr. Cutler wondered if the hospitals of today are not just "beautiful nonentities" and if in the hospitals of the future every room will be a laboratory, every room an operating room.

Design in the Afternoon

An innovation in hospital planning practice, cocktail bars for ambulatory patients and drinks via room service, like downtown, for patients whose doctors don't object, was proposed at one of the dollar-stretching sessions by Edward E. James, director of North Shore Hospital, Great Neck, Long Island. Mr. James urged a standing-room-only audience of architects, consultants and administrators to plan their hospitals for flexibility, so that major alterations may be made as changing practices require.

In another departure from time-honored practice, Mr. James suggested "opening up" heretofore hidden departments of the hospital, so that patients and visitors can see for themselves what goes on behind the scenes.

Gordon A. Friesen, senior hospital administrator for the Memorial Hospital Associations of Virginia, West Virginia and Kentucky, made a spirited plea for architects, administrators, physicians and major department heads to get together frequently in preplanning sessions to establish the kind of rapport that results in hospitals whose patients are regarded as psychic and spiritual, as well as physical, organisms.

On the same program, Dr. Robert Lowe, administrator of Rochester General Hospital, Rochester, N.Y., suggested putting the formula room in central supply—a suggestion from which listeners recoiled in horror at first, then, as they heard the rationale set forth by Dr. Lowe, turned to each other and asked, "Why not?"

Purchasing

The purchasing session was a good buy for any convention shopper, and some 350 persons requisitioned seats.

You can stretch the hospital dollar by outside contracting for certain services, George A. Hay, administrator of the Hospital of the Woman's Medical College of Pennsylvania, maintained. But when it comes to the purchasing, pharmacy and housekeeping departments it seems wiser not to bring a third party into the situation.

Painting can best be done by the hospital's own staff, Mr. Hay holds, but printing can be expertly handled only by an outside contractor. The important thing is that the hospital administrator must know his costs; then he can study all the services to see where outside contracts can do the job better and cheaper than can hospital employes.

Mr. Hay jerked his audience up short by suggesting an outside contractor for hospital meal service. "The colleges and hospitals that train dietitians seem to lack courses in administrative technics, in personnel management and human relations. The main cause of poor meal service in hospitals is this fundamental defect in the education of dietitians."

Reuben H. Graham, purchasing agent for North Carolina Baptist Hospitals at Winston-Salem, told the group that the first step on the way toward labor saving equipment is to form committees of key departments and employes. These committees can then study procedures and simplify and standardize them. The next step will lead them directly to supplies and equipment. Both administrator and purchasing agent must keep up with all new equipment.

Speaking on "Can Prepacking Save Money?" Ronald Yaw, director of Blodgett Memorial Hospital, Grand Rapids, Mich., said that we must get some sensible standards on the number of gauze pads and the like that are to be put into one package so that manufacturers can prepackage the correct quantity at the factory. As it is now, a great amount of repackaging by hand goes on in the hospital central supply room.

Robert G. Boyd spoke words of praise for the organization of a standardization and simplification committee. One such committee at Cleveland Clinic actually saved the hospital $8000 during its first year of operation. Mr. Boyd suggested an invasion of the storerooms with the objective of getting rid of all obsolete items.

Auxiliaries

Today their gladness overshadows their madness. Like mad they continue to raise money for the hospital. But like glad they retrieve, recruit and retain friends for the hospital. And, uniformed in their cheery cherry red, like glad they dig into hospital jobs that on today's market few salaried persons can be induced to accept.

Even the imaginative A.H.A. is staggered at the size, the glowing friendliness, and the thirst for knowledge of the national organization of women's hospital auxiliaries it created only five years ago. Some 600 delegates listened, lunched, teaed and traded technics at Philadelphia this year, and they represented more than 400,000 women.

The new slant these delegates are taking home with them is that if they are going out selling the home hospital, it is necessary that they know every facet of hospital operation. They came to Philadelphia primarily to learn, and the formal program fed them facts.

As their favorite speaker, James E. Hague, assistant city editor of the *Washington Post,* told them, they are working, down-to-earth practitioners of hospital public relations. They succeed best because of their amateur standing. Their soundest technic is word-of-mouth telling of the hospital story.

They also liked Everett W. Jones, vice president of the Modern Hospital Publishing Company, because he gave them financial facts—what it costs a superbly equipped hospital to snatch a baby from Death's hands, what the credit officer is up against, what the financial audit is and the medical audit and the value of each to the public.

Apparently it isn't hard to get good speakers for these sessions. Mabel A. Barron of Elizabeth Steel Magee Hospital, Pittsburgh, jumped at the chance to tell her needs for auxiliary help in recruiting students and employes and in explaining apparent breaches in service to an intolerant public. Sylvia J. Levie of Jewish Hospital, Cincinnati, voiced the dietitian's need for wanted help in informing the public, all of whom regard themselves as experts on one phase of hospital service, namely, food, that bland diets would be uninteresting at home, too. Trustee Edward K. Warren of Greenwich, Conn., welcomed the chance to give some danger signals in board relationships. "If the chairman of the board of trustees and the chairman of the medical board are the best of friends—that's not one red light, it's three red lights," he warned.

The delegates were charmed by a Proper Bostonian, Mrs. Augustus Thorndike, who told the story of Massachusetts General's "female visitors" of 1869, "judicious women" who assisted patients chiefly by listening to them. The experiment of 1869 is still being continued, largely because members of the visiting committee are judicious women who are particularly adept at listening.

Delegates liked the way Sister M. Michael, superintendent of Misericordia Hospital, Philadelphia, told of the dovetailing of the auxiliary's famous annual lawn party with the men's money raising effort for the hospital. They admired the greenhouse work and other activity projects an auxiliary provides for mental patients at Boston Psychopathic Hospital as told by Mrs. Henry S. Stetson.

At the closing luncheon on Thursday awards were announced in the third annual contest on annual or other reports to the community. These public relations awards went to auxiliaries of the following hospitals:

Group I: Community Hospital, Paragould, Ark.

Group II: Lubbock Memorial Hospital, Lubbock, Tex.

Group III: Abington Memorial Hospital, Abington, Pa.

The College

The honorary alma mater of 2083 enterprising hospital administrators has come of age. In the very room where a toddling American College of Hospital Administrators held her

first convocation 18 years ago, that body, ripened in dignity and allure, on Sunday the 14th gathered to her well rounded bosom a group of 275 nominees, 216 members and 90 fellows, all shining new in their respective categories.

Education with decided spiritual overtones was the theme of the Arthur C. Bachmeyer annual address, delivered at the Monday morning session of the A.C.H.A. by Clarke G. Kuebler, Ph.D., president of Ripon College. Starting in a mild conversational tone, Dr. Kuebler quickly warmed up to evangelical fervor, spiked with satire, in elaborating his thesis that freedom must not be taken for granted, it must be won and rewon—and it can only be won by the right kind of education. If the United States ever falls into the trap of totalitarianism, the switch from freedom to slavery will creep up on us from within, through sheer neglect, rather than as the result of war or revolution.

Totalitarianism, according to Dr. Kuebler's definition, is the direct antithesis of democracy in that its adherents hold that only a few men are capable of reason and that the individual must be submerged in the state, whereas democracy is built on the conviction that everyone can reason his way to the truth and that the dignity of the individual is above all price and the state is the servant of the man.

Because education is the keystone of democracy, the speaker warned, the schools are always the first area to be attacked. The churches come next. The schools must guard against the encroachment of the totalitarian point of view by educating young people to assume responsibility, to develop their critical faculties and to reason their way to the truth.

The gravest danger in the American educational system, Dr. Kuebler believes, is that we train people prematurely for professions and vocations without enough liberal training. "No one can live within his profession," he stated. "Our students must be educated beyond their professions so that they can develop their critical faculties." They must be given time to get a liberal education before they are trained for a profession or vocation.

Another equally serious danger in our education system is that young people are given "every equipment except morality and religion." Man, Dr. Kuebler insisted, is valuable because he is made in the image of God. It isn't "liberal" or "sophisticated" to have no religious or spiritual values. Every individual must worship something; if he is not taught to worship God, he will turn to worship of money, or success, or himself—or the state—to fill the vacuum.

If education of the young is to equip them for freedom, we must concern ourselves with giving them moral and spiritual training as well, and in that realm American education has been terribly deficient. The schools must remedy that deficiency, without descending into bigotry.

"And let it be when thou shalt hear a sound of going in the tops of the mulberry trees, that then thou shalt bestir thyself, for God will go forth before thee to smite the host of the Philistines."

The verse from the Old Testament with which he concluded his talk bestirred Dr. Kuebler's enthralled audience to applause such as speakers at hospital conventions seldom get. As one Catholic Sister summed up later, "It was a rare privilege to hear a man like that. Makes you realize there are still things in the world that are worth fighting for. I wish we could get him to talk to our student nurses."

Proving herself no man's or no party's captive, the college, on Monday morning, after a touching farewell to "President Ernie" (E. I. Erickson), turned eager and instant allegiance to Dr. Fraser D. Mooney of Buffalo, N.Y., new top man, meanwhile fluttering coquettish lashes at Dr. Merrill F. Steele of Christ Hospital, Cincinnati, the new "elect."

Assisting Dr. Mooney in his prexying job this year will be Melvin L. Sutley of Wills Eye Hospital, Philadelphia, as first vice, and Sister M. Conchessa of St. Louis as second vice (strike out that second vice and substitute virtue). Again heading headquarters staff will be the faithful Dean Conley whose tidy and temperate report on "Your College in Action" was warmly applauded.

New regents named for five regions are: Mark H. Eichenlaub, No. 3; Frank S. Groner, No. 6; Ray E. Brown, No. 9; B. Tol Terrell, No. 12; Dr. A.

C. McGugan, No. 13. Other regions acquire other regents other years.

In his presidential summing up, "President Ernie" mentioned proudly the enlargement of the credentials committee to nine members from three geographical areas, thus accelerating the processing of applications. Mr. Erickson reminded members and fellows that to help all hospital administrators, in and out of the college, to be better executives is part of their duty to their 18 year old alma mater.

Honorary fellowships were conferred on Dr. Arthur C. Bachmeyer and on Fred A. McNamara, chief of the federal Bureau of the Budget. The president's emblem was given Frank J. Walter.

Applause was genuine and sustained for the banquet speaker, Judge Harold B. Wells of Bordontown, N.J., whose subject was leadership. Said he: "We have more to fear from our own moral and mental decay than from the world's Communists. And remember, no one else can do the work that God has assigned to you."

Awards and Honors

In a presidential election year the ballot superseded the applause meter in naming the winners of the annual idea contest on "Stretching the Hospital Dollar." Ten finalists presented their inventions, tangible and intangible, before a Wednesday night crowd presided over by Robert W. Bachmeyer.

Next morning the returns were in and the following successful candidates were announced:

$100 defense bond winner: Sister Miriam Eveline, on her employe training program to raise morale and pride in work and to reduce labor turnover at St. Vincent's Hospital, New York.

$50 defense bond winner: Ralph L. Perkins for his mobile tricycle Stryker frame; he is administrative officer of the U.S. Public Health Service Hospital, Stapleton, Staten Island, N.Y.

$25 defense bond winner: Nelson O. Lindley, assistant director of Beth Israel Hospital, Boston, for his recovery room stretchers with removable sideboard and I.V. pole.

The awards were announced at the annual banquet on Thursday evening.

The highest honor the A.H.A. has to confer each year is its Award of Merit, and on Thursday evening this honor was bestowed on Dr. Fred G. Carter, administrator of St. Luke's Hospital, Cleveland. Dr. Carter has had a distinguished career in hospital administration.

Honorary membership in the association was extended to Luther W. Youngdahl and Anson C. Lowitz during the banquet ceremonies. Judge Youngdahl's contribution has been to mental hospitals both in Minnesota, where he was a former governor, and in the nation. Mr. Lowitz, vice president of Foote, Cone & Belding, has directed student nurse recruitment activities as volunteer coordinator for the Advertising Council.

Planning Agencies

Representatives of state and federal planning agencies and those of such voluntary associations as the A.H.A., A.M.A. and A.N.A. got together September 14 at the Association of Hospital Planning Agencies meeting to wrestle over their mutual problems and resolve some differences. Theme of the meeting was "How Can Voluntary and Official Agencies Cooperate to Achieve Better Patient Care?" and it was immediately apparent that all groups were in complete agreement on two points: (a) official and voluntary groups *can* work together, and (b) they'd better. Chief area of disagreement was the usefulness, or otherwise, of hospital licensing regulations.

Leading off for the official point of view, Gordon Cumming, chief, bureau of hospitals, California State Department of Public Health, pointed out that the first need is to define exactly what is meant by patient care from the patient's own point of view, and that includes his ability to pay for it. Both state and voluntary agencies, he stated, are primarily concerned with improving patient care in existing institutions, and in extending care to areas where there is none, or where it is inadequate. Having state licensing agencies, Mr. Cumming believes, focuses responsibility in the over-all approach in making regulations work and in coordinating data and sources of information to which hospitals can refer when they need help.

Mr. Cumming's view of the licensing program was upheld by Dr. John R. McGibony, chief of the Division of Medical and Hospital Resources, U.S. Public Health Service, who asserted that legal regulations to back up the standards set by voluntary agencies are needed for the patients' protection but that the existence of such laws doesn't necessarily entail "therapy by regulation." Licensing laws, the speaker stated, improve good hospitals and strengthen the weak.

Dr. Donald Anderson, secretary of the A.M.A.'s council on medical education and hospitals, believes precisely the opposite. Licensure, he stated flatly, is not a panacea for all hospital problems. The A.M.A.'s voluntary program to raise standards in hospitals has done a better job than licensing agencies have. Indeed, he added, licensing regulations are below A.M.A. standards in many cases and licensure has actually been known to keep competent physicians out of hospitals because of legal technicalities. Dr. Anderson cautiously admitted that government can cooperate with voluntary agencies without trying to dominate them—he has seen it happen. However, he has also seen disquieting trends that lead him to believe that in too many instances government is paying mere lip service to the voluntary agencies when it seeks their counsel without having any real intention of following it.

Speaking as president of the Association of State and Territorial Health Officers (a voluntary group), Dr. Leroy E. Burney had a little trouble remembering whose side he was on. Since he is health officer for the Indiana State Board of Health, it was not surprising that he took a swipe at the voluntary groups by pointing out that they have not been much help to the state agencies in the hospital licensing program. Health officers need the help and guidance of hospitals and voluntary groups, he said, and so far they haven't had much. Maybe, he added, the health officers haven't asked for it.

J. Milo Anderson, representing the spirit of sweet reasonableness, as well as the Ohio State University Health Center, closed the debate by asserting that there is a real spirit of cooperation between government and voluntary groups "in spite of periodic outbursts of recrimination on both sides, with government feeling that hospitals are incapable of operating their own business, and hospitals defending themselves." Both sides, he added drily, might well modify their views.

The evening session of the meeting was divided between business and monkey business. The monkey business took the form of a comedy of errors called "A Typical Community Starts a Hill-Burton Project." It was spontaneous, unrehearsed—and without a script—and everybody, actors and audience, had a wonderful time.

Survey shows hospital administrators

OVERWORKED and UNDERPAID

—but try to get one of them to quit the field!

HOSPITAL administrators, it has been asserted on more than one occasion, are underpaid, overworked and generally unappreciated members of our economic society. This unhappy view of things is confirmed, at least partially, by administrators themselves in a MODERN HOSPITAL survey covering 139 hospitals of all sizes in all parts of the country. Asked point-blank if they felt they were adequately reimbursed for their efforts to hold the conflicting pressures of patients, doctors and trustees at arm's length, most administrators said "No!" Many added illuminating comments aimed at making the point more emphatic.

After thus asserting "This is a dog's life!" the administrators quickly added that they like it that way—in fact, they wouldn't trade places with anybody. Only a handful responded affirmatively when asked if they would leave their present positions for a larger salary in another industry.

The average annual salary of all the administrators reporting in this survey was $6841, an amount that compares favorably with the earnings of straight-time skilled labor in most industries but is exceeded by plumbers, electricians and others who stay on the job after the whistle blows at double-time rates—as most administrators do routinely for nothing.

In another comparison that comes quickly to mind, it might be pointed out that according to a U.S. Department of Commerce report released last year, the average net income of physicians in private practice was $11,744 a year. This is a contrast that has not escaped the attention of administrators. Asked if their incomes provided a standard of living comparable to that enjoyed by doctors and hospital trustees in their communities, three-fourths of the responding administrators said they did not.

Inevitably, the larger hospitals pay the larger salaries. As shown in the accompanying table, administrators of hospitals under 50 beds reported an average annual salary of $4738; the average salary rises steadily by hospital size—to the respectable sum of $10,619 for reporting hospitals with 200 beds or more. A surprising result of the survey was the number of administrators who reported that they are still receiving some perquisites, or living expenses in kind, in addition to their cash salaries. More than 40 per cent of the administrators in this group are taking meals on the house; for several of them, the house itself is thrown in. This circumstance has a depressing effect on cash salary; several of these administrators get less than $3000 a year in cash, and one, acknowledging a certain discontent with the situation, reported an annual salary of $1200.

Perquisites, however, are by no means ruled out at the other end of the economic scale. A number of administrators reporting salaries of $12,000 or more are still feeding out of the hospital trough, and one of the highest salaries in the group, $18,500, goes to the administrator of a 500 bed hospital who is enjoying the executive equivalent of an old-fashioned maid-servant's "totin's."

Divided by regions, the number of hospitals reporting here is too small to have statistical significance. Nevertheless, it is interesting to note that regional variations are slight, for the most part, and the progression of earn-

ings from small to large hospitals remains steady. In Albuquerque as in Albany, the payoff is on size, a circumstance that may easily violate the sense of justice of administrators in smaller hospitals. "In this hospital of 53 beds I am hospital administrator, purchasing agent, druggist and director of nurses," one of these wrote. "I have been in the field of hospital administration for 25 years," she added. "Why is it that a nurse administrator's salary is so much lower than a man's? Frequently a nurse is replaced by a male administrator at double the salary—plus a graduate nurse as an assistant!"

The answer to this question didn't emerge clearly in the survey, which bears out only faintly, however, the popular notion that hospital administrators commonly hop from job to job like children playing musical chairs. The average period of service represented in the group was five years, a wholesome tenure, and a substantial number of these administrators have been reporting for duty at the same address for as long as 15 or 20 years. The record for holding still was establishd by one old-timer who went into office with Woodrow Wilson in 1912 and has been on the job ever since, surviving the vicissitudes of war, depression, inflation, the Democratic Party and the economic security program for nurses. Over the years, his salary was increased from $2000 in 1912 to $8600 last year. As he did in the beginning, he still gets full room and board. On the whole, administrators have not fared as badly during the inflation period as some other groups. Their salary increases over the last five years have averaged 27 per cent. While the cost of living index computed by the U.S. Bureau of Labor Statistics has increased 40 per cent over the same period, few employed groups have kept up with the index, and many have fallen much further behind. Doctors in private practice, for example, increased their earnings only 19 per cent in the latest five-year period covered by the Department of Commerce report.

Such salary increases as administrators have had, moreover, were earned in an uphill struggle. There are few contracts in the group, and few informal agreements calling for definite salary increases over a stated period of years. Furthermore, administrators who stay on the job for 25 years or more must still depend on the whims of hospital trustees for their old-age security. Only 25 hospitals in the entire group have a retirement plan for their administrators, and these, according to the reports, are unlikely to result in extended European vacations. One hundred dollars a month, it develops, is regarded as comfortable retirement pay after a lifetime of serving the sick. Anything more is munificent.

TABLE 1—AVERAGE ANNUAL SALARIES OF ADMINISTRATORS

Group	Average Administrator's Salary Today	Average Number Years on Job	Average Salary When Employed	Pct. Increase
54 hospitals under 50 beds.....	$4738	5	$3743	26
34 hospitals 51-100 beds.....	5343	5	4521	18
27 hospitals 101-200 beds.....	9539	4	5609	70
24 hospitals 201 beds or more.....	10619	10	7707	37
139 U.S. hospitals.....	$6841	5	$5022	27

Meanwhile, however, life for the administrator has not been without its brighter moments. When convention time comes around, the average administrator is off to the races, with nobody looking over his shoulder to count the hospital's dollars as he spends them. Asked to classify the expense account arrangement under which they attend hospital conventions, 40 administrators said their expense accounts were liberal, 45 described the arrangement as average, and only 23 said authorized expenses were held to a minimum. Twenty-nine administrators dig into their own threadbare pockets for convention expense funds, and two reported sadly that they just don't go.

To the extent that it is discernible in these reports, hospital administrators are at least as contented with their lot in life as the next man—and a lot happier than one would expect, judging from their salaries alone. Few feel that they are adequately compensated, considering the salaries earned by executives with comparable responsibilities in industry, but the majority appear to accept this unfortunate circumstance cheerfully, regarding penny-pinching as an established fact of life. A certain amount of self-righteousness emerged in replies to the question, "Would increased salary improve your effectiveness?" "I do the best I can without respect to compensation," was a typical answer. "I am happy to serve to the best of my ability and strength," another administrator declared, adding sententiously, "Money is not the basis of happiness!"—a proposition that has been defended by philosophers since the time of Aristotle but will still start an argument in most occupational groups. A few administrators seek to justify their small salaries on the ground that this is all the hospital can afford. "I feel this small hospital is limited as to the amount of salary it can offer," one such executive stated. "Professionally, one does not regulate their efforts to the salary given," said another, with more attention to rectitude than to syntax, "but rather to the needs of the institution."

Others reached the same general conclusion by a less sympathetic route. "The average board of trustees is struggling with the old dollar sign," said one of these. "Too many trustees lack the foresight to know that a worth-while administrator can make or break the hospital. It is difficult for an administrator to plead his case; it is easier to change jobs." The same correspondent had another rap for hos-

TABLE 2—ADMINISTRATORS' SALARIES BY REGION

Region	−50 Beds	51-100 Beds	101-200 Beds	201+ Beds	Average All Sizes	Average Years on Job	Average Salary When Employed	Pct. Increase
Midwest.....	$3841	$5667	$7979	$15,200	$6151	5	$3818	61
Mid-Atlantic.....	7000	4200	7412	9,023	7684	6	5379	42
New England.....	2917	5550		14,500	6103	7	4912	24
Southeast.....	4500		7100	8,932	7371	10	4528	63
South.....	4140	5166		12,000	5355	4	3788	41
Southwest.....	5780	5100			5800	3	5180	12
Mountain.....	4776		7050	12,500	6458	6	4598	44
West Coast.....	6377	6450		9,300	7026	4	5429	29

pital boards. "Administrators are being produced by the various schools at such a rate that the graduates, mostly men, are being offered the top jobs. These graduates lack the real experience which is necessary to good hospital administration, yet the large numbers being graduated are flooding the field."

Examined under a microscope, this comment would probably reveal two strains that were not uncommon in this group of administrators. One is the resentment of the older, experienced administrator who has learned his job the hard way, as he sees it, toward the younger men, fresh from their courses in hospital administration, who are walking off with many of the better jobs in the field today. The other strain is the resentment of the female of the species toward the male, who invariably gets more money for doing the same work. This was not determinable from the present survey, but a previous MODERN HOSPITAL study showed male administrators making an average of 30 per cent higher salaries than women did.

Regardless of sex and experience, however, many administrators in today's group are convinced they could do better work if they had more money. Some who are fighting a losing battle with the mounting demands of growing families indicate that relief from the nagging burden of financial worry would improve administrative efficiency; others say frankly that they could deal more effectively with members of the medical staff if their salaries permitted a standard of living which would enable them to meet staff and board members as social equals. "The respect and prestige that go with one's standard of living would help me with the medical staff," said an administrator whose $6000 salary keeps him locked up in the community's social cellar. "With an adequate salary," he continued, "I would not be made to feel like an 'inferior layman.' I could then meet doctors and board members on more even terms, instead of as a subordinate employe." The same comment, in practically the same words, was repeated time after time in these reports.

At the higher salary levels, administrators have traded in their worries about social status and paying for the children's education; instead, they brood about retirement pay and the income tax. Several administrators in the $20,000 a year bracket referred wistfully to the liberal expense accounts, stock options, long-term contracts and other devices industry has developed to help its top executives fend off the wolf in these tax-ridden days. "Hospitals offer very little except a cash salary," one administrator observed. "Too few boards realize that salary increases are not a panacea for all management problems. Hospital people are devoted to their calling; hospital executives are probably subjected to more human relations pressures than any other group in our society. They do not expect great monetary returns, but society should give them more security. Administrative budgets need to be enlarged to provide life insurance, retirement endowments and expense accounts for club memberships, travel to educational meetings, automobile expenses and other needs that are met routinely for executives in industry today." Remarking on the incidence of coronary artery disease among hospital executives, another administrator concluded tartly, "Hospital boards should consider insurance programs as benefits for the widows."

Nevertheless, the average hospital administrator wouldn't change jobs with anybody—except another hospital administrator. More than half of those responding in this survey said they would leave their present positions to accept a higher salary in another hospital, but only 29 said they would consider leaving the hospital field—at any price. The reasons are expressed in varying terms, but they add up to the inescapable fact that hospital administrators are proud of their occupation and get huge satisfaction from doing good. "I'm in this business to stay," said one young administrator, obviously speaking for the entire group, "—show me any other job with half as much personal gratification!"

There's no short cut to NURSING LEADERSHIP

nursing leaders may be born—they also must be trained, beginning in the classroom

EVERETT JOHNSON
Administrator, Chicago Memorial Hospital, Chicago

IN THE promotion of a nurse to a supervisory position, a minimum of emphasis should be placed on her length of service on general duty. It is a fallacy to use longevity as the only criterion in determining leadership capabilities. Witness the failures of many older nurses who do not succeed when promoted to head nurse, even though they are excellent bedside nurses.

This situation was demonstrated by an excellent general duty nurse who was promoted to the position of head nurse, on a private division, after 15 years' service in the hospital. With such a long work period on this nursing unit it was felt that she would make an excellent head nurse because of her accumulated technical experience. Shortly after her appointment, this private division nursing unit was the cause of complaints from many sources. An investigation was made to determine the cause. It was soon obvious that the new head nurse was indeed quite competent technically, so much so that she placed little value on spending her efforts to work well with other departments, in accepting responsibility for administrative reports, in planning daily schedules, or in teaching her personnel, and in the many other administrative tasks required of her in the new position.

REFLECTS ON THE DIRECTOR

This error of selection is not a reflection on the nurse, but on the director of nurses or hospital administrator who failed to recognize that leadership development is not learned through repeating routine nursing duties year after year. Psychologically speaking, the willingness to acquire supervisory knowledge is a function of the desire and energy with which it is pursued and the rate of learning of the individual nurse.

While a skillful general duty nurse will always be considered for promotion, it should be recognized that technical proficiency is not the primary ability needed to direct a nursing unit. People associated with large business corporations or government agencies can easily recall many examples of the limitations of leaders promoted only on the basis of technical skill. They often lack an appreciation and understanding of the social factors needed for success in their new position and are not aware that the art of persuasion is a necessary attribute of a leader.

With the rise in the use of chemotherapy and the closer patient supervision required because of it, with more and more complex mechanical equipment on nursing units, and with greater use of unskilled and semiskilled nursing personnel, the value of good nursing administration continually grows. The hospital administrator and director of nurses should frequently and objectively evaluate the standards used in selecting supervisory personnel, thus assuring the hospital of a rising standard of nursing leadership. This must be done if the nursing service is to develop leaders capable of meeting the future needs of medicine.

Nursing supervisors must have confidence in their own ability to use effectively administrative technics in ward management. In these days of functional nursing and the nursing team it is only a short time after graduation that the R.N. finds herself directing other people, such as nurse's aides, practical nurses, volunteer ward aides, ward clerks, and orderlies. The shortage of nurses often forces a nursing administrator to promote a recent, inexperienced graduate to the position of charge nurse or head nurse with the hope that her undergraduate work has made her capable of handling the additional authority and responsibility.

NOT TRAINED IN MANAGEMENT

Except in the largest hospitals, seldom is an attempt made to train general duty nurses in ward management before they become head nurses. Consequently, many head nurses and supervisors are not familiar with the methods used by leaders to obtain cooperation and coordination and their nursing personnel often has a feeling of insecurity. The untrained head nurse may soon be haggling and

bargaining with the nursing unit employes instead of leading them through the proper use of her leadership training. This is caused by her lack of awareness of the importance of building the employes' confidence in her by maintaining their individual respect and integrity.

Both the confidence of the nursing personnel in the supervisor and the confidence of the supervisor in herself can come only through a combination of training and experience. If either training or experience of a supervisor is incomplete she will lack confidence in herself and will soon display it by avoiding issues, not admitting errors, withholding unpleasant truths, and appearing insincere. When such signs appear it means that the nurse leader does not understand the new technics she is using and more time should be spent in giving her additional training in ward management.

A second area of confusion, which should be more clearly defined in the leading of a group is the function of majority opinion as compared to unanimity of opinion. An understanding of the situations in which each is applicable as a method of action is important. Occasionally, a general duty nurse or nurse supervisor may remind the administrator that democratic action, or the use of the majority opinion, should be the basic method of determining actions of management and that no decision should be arrived at without respect for this process. Such a suggestion indicates that the person making this point does not understand cooperative action and the need for complete agreement in action, which is the basic concept of good administration.

COMPLETE AGREEMENT ESSENTIAL

The use of this method in the operation of a hospital is mandatory because the character of the work demands almost complete agreement at all times. Technical nursing skills are acquired and developed only through long hours of instruction and practice. To achieve the maximum effectiveness of these abilities they must be routinized and synchronized into habitual behavior. The use of the majority opinion, on the other hand, allows a member of the nursing unit to disagree openly, but there must not be a carry-over into a refusal to act. If a disputing minority can openly continue to reject any authority and refuse to continue to work toward the accomplishment of an immediate goal, absurd situations will exist in nursing where, at times, action must be quick, unquestioned and with no time for debate if the desired result is to be achieved.

Technical proficiency alone is not enough to make a good supervisor.

The development of adequate nursing leadership may be restricted by three general policies recommended by national nursing organizations. The first one is the traditional emphasis placed on the importance of the technical skills in nursing. National nursing organizations believe that all nurse administrators should have an R.N., and state licensing laws reflect the belief that technical attainments are of primary importance to good nursing administration. As a result of this belief hospitals have made little effort to use nonnursing personnel in supervisory capacities.

Technical nursing skills are of the highest importance at the general duty level but decrease in value as greater reliance is placed upon administrative technics. The importance of this proposition has gained considerable recognition in highly technical industries in the last 10 years. The emphasis in selecting and training prospective management personnel has shifted from engineers specialized in one limited field to persons with training in many phases of the industry. The same factors which have caused many industrial concerns to recognize this situation also operate in the hospital nursing situation. There is a level in any organization, including the hospital, where the importance of administrative knowledge outweighs the importance of technical skill.

CURRICULUM IS INADEQUATE

A second policy of concern is the failure of national nursing groups to promote establishment of a nursing curriculum designed to develop those administrative skills of perspective and balance. While these qualities may be developed in a position of responsibility, educational background is important as it increases the depth and breadth of both attributes. Good administration is to a large extent centered on the social sciences. As yet hospital schools of nursing present few courses in this educational area. Even graduate university nursing programs offer limited opportunities for this type of study. They usually select a few basic theories from the social sciences and develop these ideas in terms of their application to nursing. This does not allow the student an

opportunity to explore the social science departments of the university through interdepartmental registration. By presenting these theories in nursing courses, the schools emphasize the nursing aspects rather than the over-all implications of such theories, which are the most important for continual improvement in administration.

The third policy the national organizations sponsor is in the forefront today. It is the promotion of the idea that intellectual ability and training is the most important quality in actual leadership. Because national nursing organizations strive to achieve the goal of intellectual training through formal education they create many problems. The intellectual skills required for good leadership are necessary, but are not as important for success as are four other skills which will be discussed later. This does not imply that formal education should be discarded. Quite the reverse is true; as nursing becomes more complex, emphasis upon a carefully outlined program of didactic and clinical training for nursing leadership becomes increasingly valuable and necessary.

EDUCATION NOT GUARANTEED

Often overlooked in evaluating formal nursing education is the process of selection inherent in it. Nurses attracted to graduate study in nursing administration usually possess those qualities essential to the development of capable nursing executives. The greatest objection to this system of formal education is that there is no guarantee that graduates are in truth educated, though they may have gained considerable knowledge. Anything short of this goal tends to develop a nurse with an attitude of reliance on published material and a suspicion of the ability of a nurse without this training to learn through experience. Formal education has a tendency to develop nurses who think calmly and deliberately. The ability to think reflectively is not nearly as important to the head nurse as it is to the director of nurses and it may impair a head nurse's ability to handle a nursing unit where the situation is ever-changing, unpredictable and sometimes unstable. In such an environment the planning ability of a nurse may be frustrated and lead to dissatisfaction with her position.

In evaluating a program of formal education, the fact should not be overlooked that our present social system uses the college degree as an index of determining social status. As a result, such social values lead to the development of an attitude of intellectual snobbishness. The elimination of this attitude is important to the nursing profession if capable leadership is to be achieved. An example of the current force of this attitude is noticed in the increasing demand that supervisory and administrative nursing personnel have at least a baccalaureate degree. Yet, this policy will exclude nondegree nurses from developing into positions of leadership, and the hospital will fail to develop some fine nurse leaders for the future. To lead a nursing group, the successful nurse supervisor must understand situations in which she is involved. This requires a keen interest in her associates and an understanding of their philosophy of nursing. If a head nurse permits herself to become inordinately proud of her intellectual achievements she lacks a sympathetic understanding of both personnel and patients, and soon is ineffectual as a leader.

Formal education of nurses stresses the need for each student to develop a high degree of technical proficiency in her work. This leaves little time for her to acquire an understanding of the organization and administrative technics required by a successful head nurse. During her undergraduate years a student seldom has an opportunity to become a charge nurse. Consequently she does not usually acquire the practical knowledge that comes only with the experience of solving problems of organizing personnel and equipment. If such an experience could be provided during the last part of the senior year, and tightly controlled by a preceptor type of instruction, student nurses would have a better understanding of a head nurse's responsibility. A student trained by this method is more likely to make proper operating decisions and to develop a leadership personality.

A successful nurse administrator knows what is expected of her and how to achieve cooperation within the nursing department and with the other departments of the hospital. She must be aware of the ways in which she can influence attitudes and develop interest in achieving the objectives of the department through the use of her own personality and persuasive powers. In the hustle and bustle of daily nursing routines, and with changes in medical technics and rapid personnel turnover, the long-range goals of nursing frequently are obscured. A continual task of the administration is the definition of these objectives in terms of their application to everyday problems. If this is done personnel will be aware of the goals of the hospital and how their work contributes to this accomplishment. Clearly defined objectives arouse the sympathy and interest of nursing personnel and determine the success of the department. If there is a considerable amount of bickering and indecision in a nursing department, there has usually been a lack of skill in defining goals. Consequently, there is a lack of discernment in separating important from unimportant work. When such a situation prevails internal and external cooperation rapidly decreases in the nursing service. Interdepartmental and intradepartmental communications become restricted and the work situation becomes progressively more unstable.

WORK LOAD WAS TOO HEAVY

The following example shows the value of the everyday job of defining immediate objectives for a nursing unit. A well trained head nurse was responsible for a medical and surgical unit that was running at more than capacity. This situation prevailed on all nursing units, but on this particular one it was noticeable that the personnel turnover was the highest of any nursing unit. Complaints were continually made by the employes and there appeared to be general job dissatisfaction. It was apparent that the quality of nursing care was lower than should have been expected under these conditions. On studying the nursing unit it was found that the head nurse was not giving explicit instructions to each member of her team. With the extra work load such instructions became more important than ever, and her failure to give them resulted in the work's falling unevenly on the nurses and creating pressures. The complaints were symptoms of this fact.

With the previous discussion in mind it becomes necessary to consider the skills desirable in a nurse leader. These skills must be recognized and encouraged if adequate leadership is to result.

The most important skill of a nursing leader is an ability to arrive at a decision that can be put into operation. To do this she must have the ability to collect facts, evaluate them, and make a decision. To avoid or pro-

crastinate on necessary decisions is to fail to give the direction required for maximum efficiency of the nursing staff. This may result in an undermining of its confidence and cooperation. When decisions are made it must be remembered that unnecessary ones will thwart the initiative and imagination of the nursing personnel.

Next in importance is a sense of responsibility: the higher the required standards of performance (owing to increased use of intravenous solutions, antibiotics, and so on), the more necessary it becomes to supervise the employes of the nursing unit. As the level of performance increases a commensurate feeling of responsibility must be developed. This feeling of responsibility may become a point of irritation within the nursing service, frequently at the head nurse level, where medical knowledge and administrative responsibility merge if established policies are not carefully followed. Probably the most frequent source of difficulty for the head nurse is caused by a physician's failing to follow administrative regulations of the medical staff. For example, if a physician fails to write the diagnosis for a patient with a communicable disease, such as tuberculosis, and the head nurse recognizes this as a possibility she is faced with a dilemma caused by divided responsibility. From the medical standpoint a nurse should not diagnose, and yet on the administrative side she is responsible for the protection of her nursing unit personnel. The solution to this situation will cause her to feel considerable pressure and tension before she reaches a decision.

SHE MUST BE OBJECTIVE

A third skill of leadership is the proper use of personality by nurse leaders. If used properly it will go far in eliminating those obstacles created by prejudiced attitudes and cross-purposes which interfere with the success of the job at hand. One quality of personality which should be mentioned separately is emotional stability. To maintain confidence, coordination and effective communication a nurse leader must remain objective, even though daily pressures and tensions create a desire to jump to conclusions or to vent emotions on her employes.

A nurse leader's intellectual skill may develop through education and training. This quality aids in attaining a position of leadership, but it must be reinforced with an ability to make decisions, a sense of responsibility, and an attractive personality. Intellectual capacity cannot be substituted for any of these other essential skills.

From a review of present educational programs for student nurses, and in view of the responsibilities and authority they assume upon graduation, it appears that several changes should be made in the traditional curriculum if present and future needs of hospitals are to be met. High nurse turnover, increased use of auxiliary personnel, and a shortage of R.N.'s make urgent the development of adequate team leaders, charge nurses, head nurses, supervisors and nurse administrators.

A realistic approach to these problems is to consider a basic change in the curriculum of nursing education in hospital and university programs. The schools must recognize, of necessity, that nurses must be trained as leaders. In the last year of their education emphasis on technical proficiency must not remain the primary objective. Student nurses should be required to select a field of specialized training prior to their senior year. For those who select hospital nursing the curriculum should be planned for a work situation where they are taught to direct other people on a nursing unit. This can be accomplished through classes in ward management which are based on the technics of good management and organization. The program should be based on the principles of administration as they apply to nursing and not vice versa. This can be carried out by a preceptor type of arrangement during the student's last year of clinical experience. The development of student nurses into nurse leaders will be accelerated by the adoption of this method, resulting in a more efficient nursing service and a higher quality of nursing care for patients.

A realistic program is needed

When Western Medicine Goes East

AN INTERESTING inquiry into the effects of the introduction of advanced Western medical science, to mid and far east communities, appears in "Western Medicine and Eastern Peoples" by A. Leslie Banks, professor of human ecology at Cambridge. The article appears in the Aug. 11, 1951, issue of *Lancet*.

Setting up an imaginary country of "Nomansland" Dr. Banks describes the effect of the latest advice from any or all of a dozen health commissions. No attempt is made to correlate the medical program with the basic economy of the country or its socio-cultural milieu. Instead an attempt is made to force a pattern of health developed in and suited to an industrial-urban culture upon a country whose basic economy is agricultural and whose religious and cultural patterns are village centered.

Beautiful modern hospitals are erected, despite a complete absence of nursing staff; elaborate statistical evaluation is attempted even though the total population or even the total number of villages is unknown; modern sanitation and preventive medical programs are instituted and immediately disturb the balance between high birth and high death rates. The immediate result of the programs is to further socio-economic disturbances. Malnutrition becomes even more prevalent as the population increases and the food supply remains constant. "Streptomycin is a wonderful drug," the author maintains, "but is useless for a boy who lives on bread and has never tasted meat or milk. Streptomycin will not cure that boy's starvation."

The author pleads for a realistic village centered health program coupled with "improved irrigation, soil fertilizer, and the help of a plant geneticist in selecting the best strain of seed." Training programs in nursing, midwifery, must be substituted for the existing servitude of women. "Our most valuable contribution from the West, the author concludes, will be to place our vast experience in a training of doctors, nurses and other health workers at the disposal of the eastern peoples."—JOHN D. THOMPSON.

Time and Motion Studies in the OPERATING SUITE

FREDERICK E. MARKUS
Markus & Nocka,
Industrial Designers and Engineers, Boston

THE RECOVERY ROOM

THE nursing service in the recovery room is of an extremely critical nature. For the nurse it is a strenuous assignment. Therefore, in the interest of the patient during this critical period and to ease the work load of the nurse, every effort should be made to provide an arrangement of facilities that produces maximum efficiency.

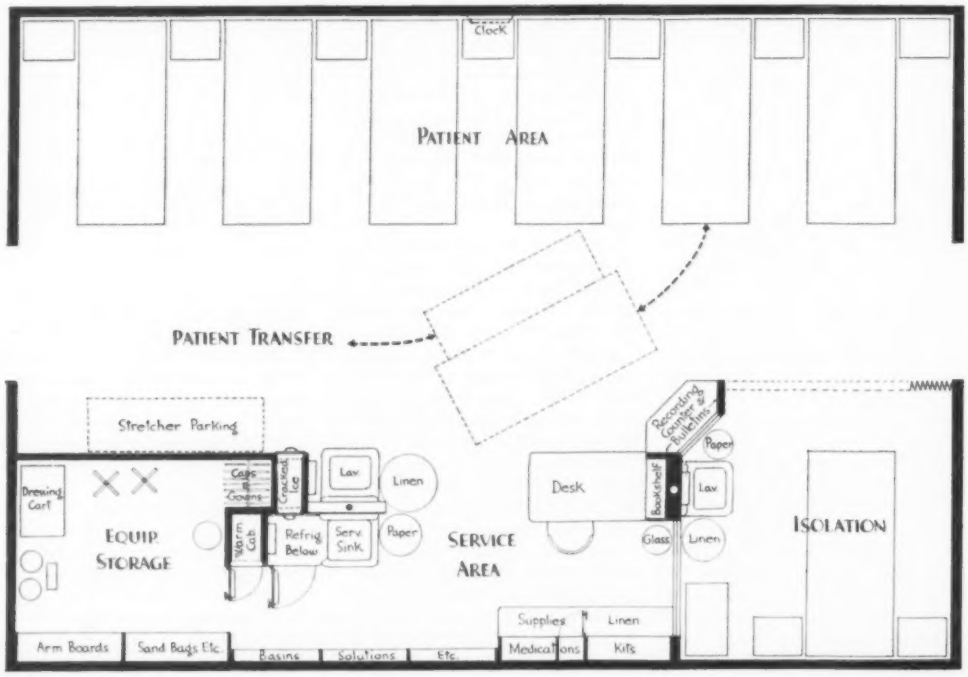
Using by way of example a capacity of seven beds and basing our thinking on observations and flow studies made in recovery rooms, we first want to divide the room into five areas as noted at right under "Space Allocation." Space for circulation and patient transfer must obviously be in the center. Next in importance are the services. They should, therefore, be as central as possible.

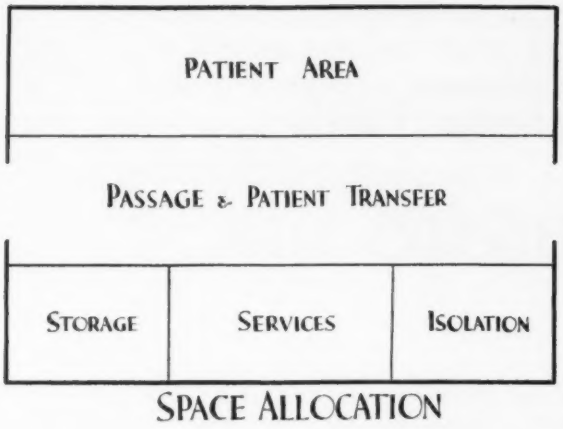
The recovery room nurse covers considerable mileage during a day's work. However, not only should travel be reduced for the nurse's benefit but there are frequent emergencies when she must get to a patient's side with great speed.

Two factors will help: (1) spacing the beds no farther apart than is necessary for proper service (we have assumed 24 inches for between-bed space although some nurses use by preference a space of only 20 inches); and (2) eliminating doors wherever possible because opening and closing them is time consuming during emergencies, and swing conflicts can introduce hazards.

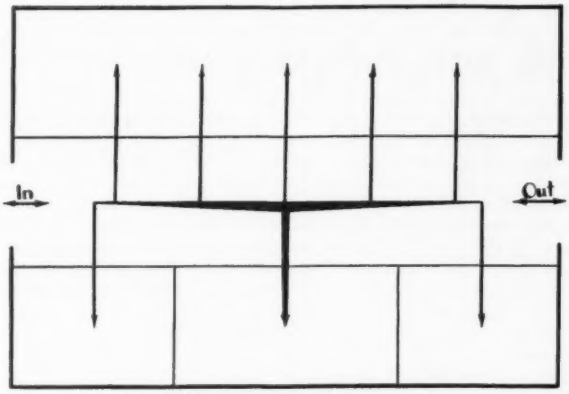
Equally important is unobstructed visibility from any work station. Note that in the example worked out here there are five work stations. From any one of these five stations, the nurse can keep an eye on any or all patients. In addition, these work stations are approximately equidistant to the center of gravity of the bed area.

In existing recovery rooms, one finds many often used items located at the end of the room. Obviously, time could be saved if these items were somewhere near the center of the room. It is sometimes difficult to locate every piece of equipment ideally but as-

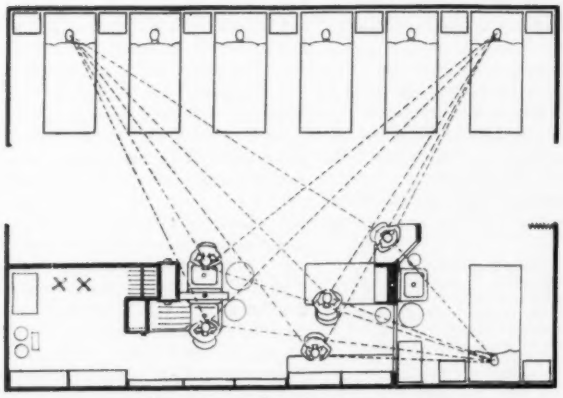




SPACE ALLOCATION



TRAFFIC FLOW



SIGHT CLEARANCES

With Reference to Visibility from Work Stations

siduous study and some ingenuity can accomplish it. The items we have especially in mind are such things as lavatories, soiled linen hampers, and a bulletin board where the O. R. schedule is posted for quick reference.

The hypothetical example illustrated here shows that it is possible to bring these items fairly close to the center of the room.

Another serious deficiency of most recovery rooms is lack of storage for apparatus and other bulky items. Such things as arm boards, sand bags, I.V. poles, and oxygen tents should have an easily accessible space set aside specifically for them. In addition, apparatus of one kind or another tends to increase in hospitals so a certain amount of extra space should, if possible, be allowed for normal expansion.

WRITING STATIONS NEEDED

Most recovery rooms provide no desk for the nurse. It is true that there is not a great deal of paper work to do and nurses questioned say they can manage without one. However, if for no other reason than to give the nurse a legitimate chance to sit down for a change with an opportunity to relax, a desk is certainly desirable.

There is, however, another place for writing which a recovery room needs that seems never to be provided. That is a place where entries can be made on charts while the nurse is standing. The need for making these entries often occurs at critical moments when there is no time to sit down. They are literally made on the run. There is still a question in our own minds whether even this arrangement is adequate. It may be that every bed should have its own writing station so that the time interval between observations and recording would be reduced to practically zero. If the nurse first has to walk to a writing station, there is a chance for error from some distraction. Further studies will be of interest on this point.

Another item not at all satisfactory is the bedside table which acts as a storage place for certain items and as a work area. As the former, the conventional table is rather meager, too low, and is needed on both sides of a bed. It also functions poorly as a storage unit. These items are mentioned to emphasize the need for further study. Such studies are made difficult in most recovery rooms by the fact that the facilities generally provided are so lacking in essentials that refinements are not yet possible to evaluate.

A British Administrator Touches the PHILOSOPHER'S STONE

SCATTERING pearls of philosophical wisdom is commonly associated with men approaching their dotage. Rarely does the expression of a man's life-long experience contain crystals of brilliance or gems of lucid beauty. Too often it is a murky sediment composed of equal parts banality, bathos and pompous drivel.

However, in an address before the Sheffield Institute of Hospital Administrators and published in the *Lancet* for July 5, 1952, as "A Philosophy of Hospital Administration," Stephan Taylor, M.D., surveys his career of administrative experience in nine English hospitals with profound insight and judicious clarity. Although the basic technics of administration, in his opinion, are the same for all large-scale group activities, the hospital administrator, by virtue of his unique position, has the power to do considerable good or immeasurable harm.

HE IS AN ARTIST

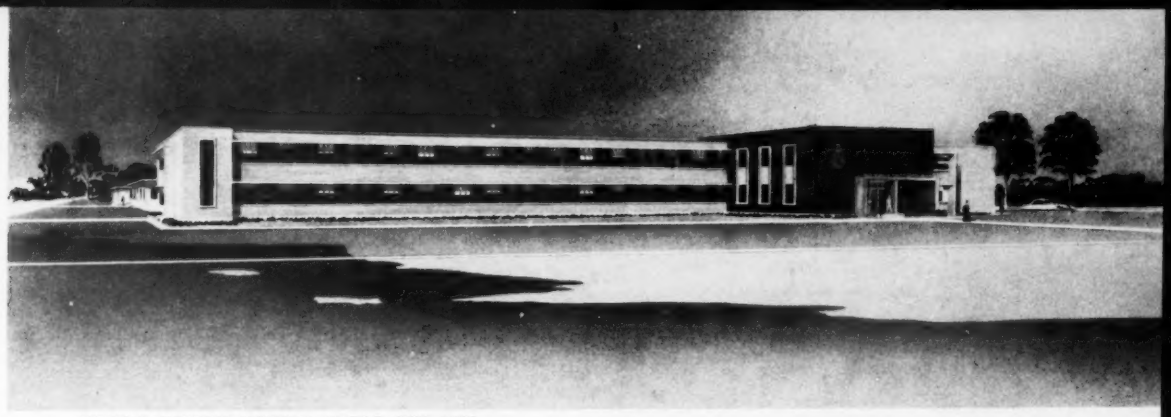
The great administrator is a creative artist with true humility, a spirit of adventure and an inner driving force to get things accomplished. He is an individual who puts the patient in the center of the picture and leaves no room for snobbishness, pomposity, false values or magnification of the trivial. He is a man of speech and action who refuses to be desk-chained, who is ready to take risks, who is "the exact opposite of respectability, of playing for safety, of pension-itis and all the other signs of a desire to gain security in a changing world and sell his soul for a mess of rather dull pottage." The bad administrator can be a nuisance or even a menace for he can create malice, frustration and hatred. He is an individual who shows symptoms of important-itis, who creates over-large staffs to hide his incompetence, who over-administers by prying into the work of his subordinates and colleagues and who is, more often than not, lazy.

Evaluating the common factors in administration, the author places foremost in importance the handling of the many personal problems and difficulties arising in large groups. In dealing with human problems, employes should be made to feel that their jobs are important to the hospital, that a full day's work will leave little or no time for fancied complaints and dissatisfactions and that the door must always be kept open for group negotiation. Other factors mentioned include the planning of departmental structures with almost complete autonomy but controlled broadly by central authority; factors relating to finance, supplies, storage, purchasing, taxes, rates and the other myriad functions of a hospital. Last, the medical audit, which is an evaluation of the hospital's medical service, is brought under scrutiny. Doctors' resentments against the administrator should be regarded as an understandable reaction against their autonomy but the medical audit of each individual physician is best done by a medical board composed of chiefs of services, as practiced in American hospitals. The author also advises that any hospital of over 600 beds is too large and may suffer from spontaneous disruption and that to ensure definitive action, a hospital executive committee or board should be composed of not more than seven members instead of the usual groups of 30 which too often tend to wallow in disagreement and stagnation.

Obviously, the job of the administrator is to make things tick. But, he must also be wary of "empire builders" and "be able to distinguish the good man faced with a genuine need for expansion from those who desire to build for the sake of self-importance." Significantly enough, some of the greatest scientific works were done in humble environments. Creative scientific work can be accomplished with small expenditures of money and materials. Marble magnificence often indicates something second rate and probably the elaboration of an individual's self-glorification.

PRIVILEGE MUST BE EARNED

In similar vein, the author points his finger at the English physician who regards himself as a privileged character because of his professional position and his exceptionally high cash rewards which set him apart from the rest of the community in a sterling-plated tower of isolation. "But," he warns, "privilege is to be earned and won by service, and each generation of doctors must earn and win it anew." Quality of service is, then, the very essence of a man's performance and the administrator who seeks superlative achievement, who wishes to establish a tradition for succeeding generations to follow, must adopt a philosophy of open-mindedness, adaptability and humanity in his service to mankind. Only thus will he avoid the mire of mediocrity and the despair of defeat.—S. W. FRIEDMAN, D.D.S., *assistant director, Montefiore Hospital, New York City.*



KING'S DAUGHTERS HOSPITAL, YAZOO CITY, MISS.

THE MODERN HOSPITAL OF THE MONTH

This Hospital Has All the Elements

JAY T. LIDDLE Jr.
Trolio and Liddle
Architects
Jackson, Miss.

THE 60 bed King's Daughters Hospital at Yazoo City, Miss., has been planned to meet the excellent departmental suggestions described in "Elements of the General Hospital" as published by the Division of Hospital Facilities, Public Health Service. With the fine cooperation of the local hospital board of trustees and staff the planning proceeded in accordance with the program prepared by the Mississippi Commission on Hospital Care.

All facilities have been designed for a 90 bed hospital. The additional 30 bed nursing unit may be placed over the rear one-story service department wing when the future need arises. The location of the building on the site has also provided for the future addition of an outpatient department on the north end of the building adjoining the adjunct diagnostic and treatment facilities.

The planning of this hospital, with most of the rooms in the two-story section stacking, makes for an economical mechanical system. The toilet rooms are one above the other and adequate chases are provided, thus simplifying the plumbing system.

The operating and delivery suites are on the second floor which simplifies the air exhaust system required in the air conditioning system for these rooms. The air conditioning required for the operating and delivery suites is handled by an air handling unit located near the suites and supplied with chilled water from the water chiller in the boiler room. Steam is supplied to the preheat and reheat coils to handle heating and humidity control. Each conditioned room has individual control even though it is being supplied by the same machine.

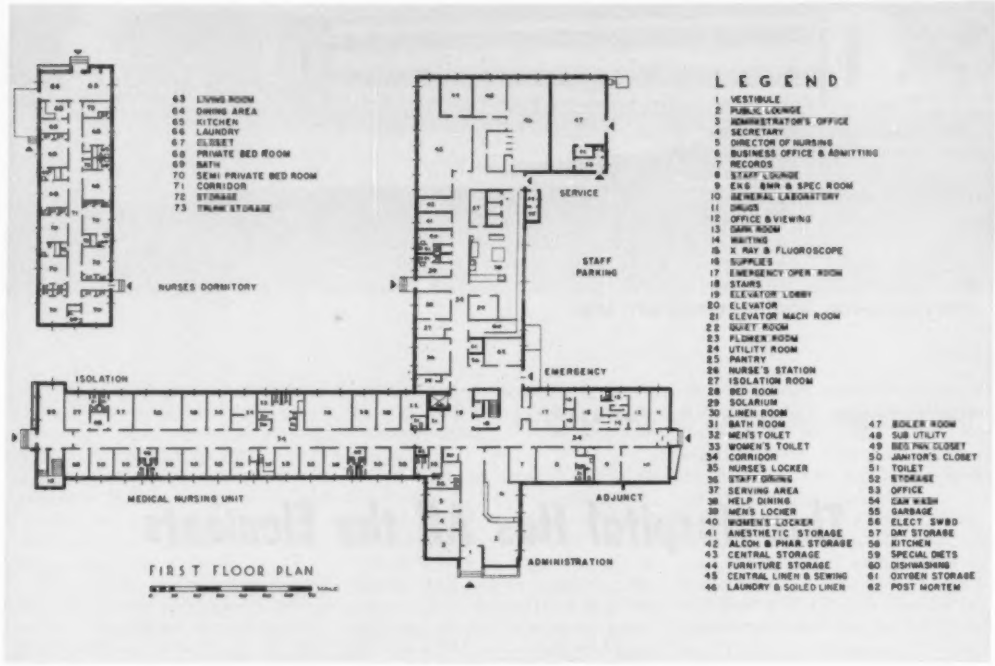
Lighting is of the incandescent type in corridors and patient rooms, as well as in adjunct, surgical and service areas. Corridor lighting is by flush recessed fixtures in areas available to the public. Patient room lighting is produced by a bracket over the lavatory, switched at the door, and a special extendable wall bracket over the bed. The latter is adjustable for indirect lighting of the room, as a reading or doctor's examination light. Cast aluminum louvered night lights are placed in each bedroom, switched at the door. All switches in patient rooms or in rooms adjoining bedrooms are the silent mercury type.

A complete nurse call system has been provided with annunciator at each nurses' station. Doctors' paging system is provided by a coded chime signal controlled by the PBX operator. Clocks are synchronous, automatically regulated wire system, controlled by master clock in the business office.

The administrative offices are grouped in the area adjoining the main lobby and main entrance. The lobby and waiting room are controlled by the information counter and have direct access to the admitting office and business office through cashier's window or counter. The information counter and telephone switchboard are arranged as one unit for handling by one person. The administrator's office is accessible to all other offices but located so as to have privacy.

The director of nurses' office is convenient to the administrator's office. The business office provides general of-

Estimated total project cost including Group I Equipment (General Construction, Mechanical and Electrical Construction, Kitchen Equipment, Laundry Equipment and Sterilizing Equipment):	$660,000.00
Cost per bed:	$11,000.00
Cost per square foot:	19.41
Cost per cubic foot:	1.59
Total square foot area:	34,000
Square foot area per bed:	567



fice space for the clerical staff and equipment.

The medical records room is accessible from the admitting office, which in this case is a combination secretary's and admitting office.

Patients' room numbers and directional signs are provided throughout the hospital for all rooms and departments.

The nursing department consists of two nursing units of approximately 30 beds each, approximately 60 per cent of the rooms private and 40 per cent semiprivate. Four rooms have private baths, 10 have toilets with lavatories. All semiprivate rooms have lavatories. The auxiliary service facilities in the nursing unit require one-eighth to one-fourth of the total unit area and include the utility room, nurses' station, linen closet, floor pantry, waiting room or alcove for visitors, and space for parking wheel chairs and stretchers.

Each utility room has a *clean* and *dirty* section and is centrally located. The nurses' station is so arranged that the head nurse can have control over personnel and visitors.

Isolation units are included for care of patients admitted with infectious or communicable disease.

Each nursing unit is furnished with centrally located toilet room, bathroom and a bedpan closet.

Two separate toilets are provided in each of these units. Also included is a janitor's closet in each nursing unit, equipped either with a curb and receptor or a suitable sink. In the maternity nursing unit shower baths are provided instead of tub baths. Utility rooms, nurses' station, floor pantries and corridors are acoustically treated.

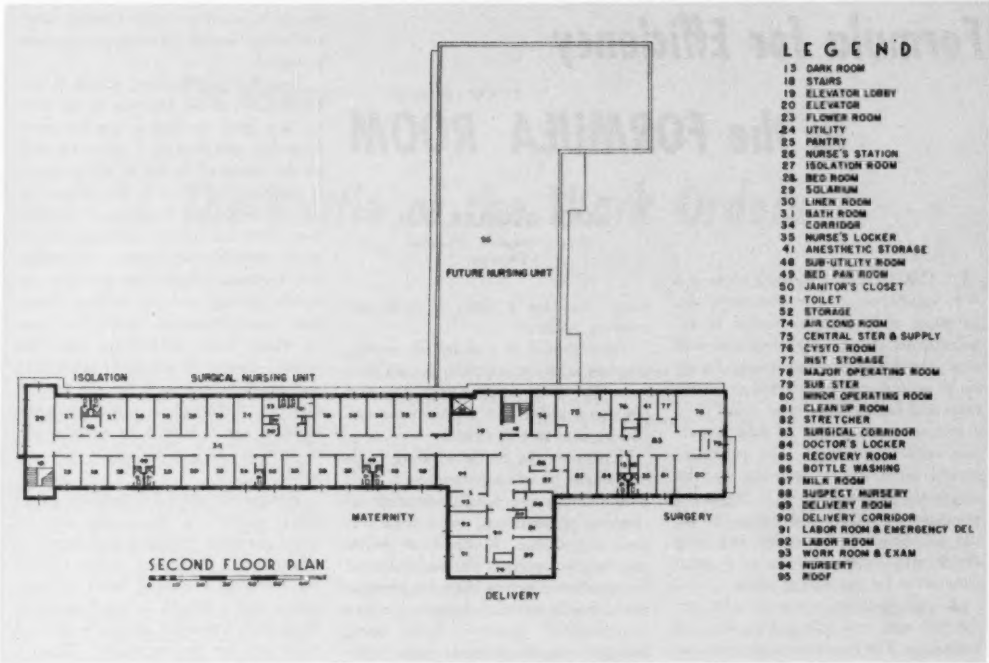
The nursery accommodates 12 normal newborn infants; it is connected to and served by a combination work space, examining room, and nurses' station. Access to the nursery can be gained only through this room. The nursery is provided with viewing windows on the corridors and with glass partitions between nursery and work-examining room. A pass window also is provided for transfer of infants from the nursery to the work-examining room.

A suspect nursery houses three bassinets for the isolation of sick babies with anteroom and entrance direct from the corridor.

The infant formula room is located adjoining the nursery unit and designed to furnish all formulas and sterilizing facilities for infant feeding. Equipment includes a sterilizer that will carry 56 bottles of 4 or 8 ounces, as well as cabinets, counter with built-in sink and a bulletin board. Space is provided for hot plate, refrigerator and bottle washer.

The emergency department is located on the first floor at the ambulance entrance and consists of a vestibule and emergency operating room with a toilet and storage closet included. Space for parking stretchers is available. A marquee protects patients from the weather when they are taken from cars or ambulance. This room is equipped as a minor operating room, but scrub-up and utility facilities are in the emergency room.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.



One major operating room and one minor operating room are included and arranged so that there is no traffic through the suite. Either the emergency room or one of the operating rooms can be used for fracture work. One scrub-up alcove with two sinks serves both operating rooms.

There is one delivery room with one labor room. These are essentially similar to operating rooms in design, including protection against explosion hazards, and are provided with instrument cabinets, special obstetrical clock, obstetrical ceiling light, which is also on the emergency electric circuit, and space for portable light, suction apparatus, heated bassinet and other essential pieces of equipment. The delivery room also has acoustical ceilings. Scrub-up facilities are similar to those provided for the operating room. All sterilizing is supplied from central sterilizing.

Space is provided in the linen room for a desk, file cabinet, and sewing machine for the housekeeper. This area is located on the ground floor and is convenient to central stores. The central linen room is designed to furnish all linen supplies for the hospital.

Shelving is provided for daily distribution of housekeeping supplies and a locked rack for the key control system is in this office. The small linen closets provided in the nursing units are sufficiently large to hold a supply for emergencies.

The linen room also has space for blanket storage, shelving and table space for mending, sewing and marking linen.

The food service department is located on the ground floor of the building convenient to the service entrance and central storeroom.

Tray service is centralized, all trays being set up completely in the main kitchen under the direction of the dietitian and transported to the patient area in insulated, heated tray trucks.

The main kitchen area comprises all space for food preparation (except special diets), serving area for trays, tray trucks, storage space, meat cutting and preparation, vegetable and salad preparation, and pot washing.

In planning the dishwashing room, we gave consideration to the traffic flow of soiled dishes from patients' and dining room areas, through the dishwashing process to dish racks and cabinets and thence back to tray serving and dining room areas. This room is treated with moistureproof acoustical material. A day storage room adjacent to cooking and preparation areas is provided for nonperishable supplies.

In a hospital of this size, cafeteria service for personnel is considered desirable for efficiency and economy. The two dining rooms are designed to serve the staff at two sittings.

A central storeroom in the service area includes space for bulk pharmacy stores, furniture and mattress storage, and all medical, surgical, housekeeping, dietary, and administrative supplies and replacement not yet issued for use in the hospital.

A fire-safe separate area in the central storeroom provides for storage of reserve stock of anesthetics and oxygen and also for tax-free alcohol purchased in bulk.

A boiler and pump room contains facilities for the heating function and furnishes steam for sterilizing, laundry, cooking and domestic hot water. The maintenance shop is convenient to the boiler room inasmuch as the same person handles both activities.

EMPLOYES' FACILITIES

Locker rooms with toilets and showers for male and female employes are located in the general service area of the hospital.

Formula for Efficiency in the FORMULA ROOM

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ALTHOUGH the formula room is a small part of any obstetrical department it is essential that it be efficiently set up, well organized and well run. The formula room should be set up in accordance with board of health rules and regulations; most states have a section on formulas in their maternity department rules. The personnel should have special training and be under the supervision of a registered graduate nurse. An aide who can do the cleaning, wash bottles and help check and order supplies is a great time-saver for the charge nurse.

A well equipped room is necessary for the safe and efficient making of formulas. The room must be clean and light. Equipment should be easy to keep clean and should be stored in easily accessible, closed cupboards. An autoclave is necessary for sterilizing equipment and formulas. A refrigerator is an absolute necessity for storing milk and other supplies, *e.g.* nipples will last longer if they are stored in the refrigerator. A small stove should be present for any formulas that require cooking. Other equipment necessary includes a sink, a desk and working counters.

There should be a closet for storing supplies such as nipples, bottles and caps. The stock supplies of canned and powdered milks and supplements can also be kept in this closet.

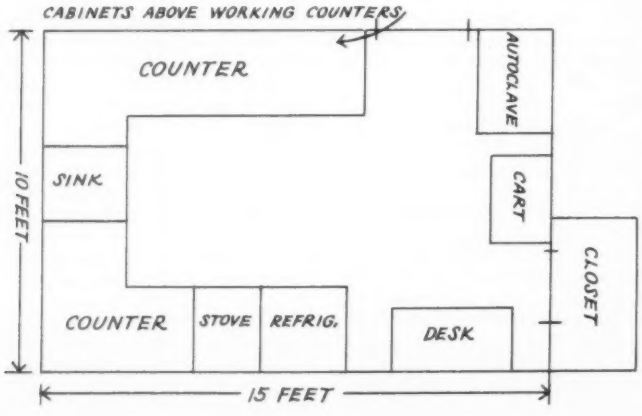
If possible the bottle washing facilities should be in a separate room. This is to prevent any possible mixture of cleaning powders and soaps with formula ingredients. Bottles from pediatrics or other units of the hospital must be autoclaved before they are brought to the bottle washing room to prevent contaminated material from being brought into the formula unit. After the bottles are washed and rinsed they are taken to the formula room.

Employes in the formula room should wear clean scrub dresses and cover their hair with some type of cap. Clean scrub dresses are worn so as to prevent possible contamination from uniforms which are worn in other parts of the hospital. The hair is also a source of contamination and must therefore be covered. While the formulas are being made the door must be closed to avoid contamination from the outside. The hands and forearms should be scrubbed with a brush, soap and water before formula preparation is started.

Terminal sterilization, which is the sterilization of the formula in the bottle, is a good method to use for most formulas; this method is recommended by the board of health in some states. It is easier and there is less danger of contaminating the formulas or nipples than with the aseptic method, which is the separate sterilization of bottles and formula followed by pouring the sterile formula into the bottles. However some formulas (such as those to which lactic acid drops must be added) cannot be sterilized terminally and must be prepared by the aseptic method. Although it is not necessary in home use it is wise in hospital use to sterilize all bottles before they are used.

Equipment needed to prepare a formula includes a measuring cup or quart graduate (marked in ounces), a tablespoon, a measuring spoon, a knife for leveling, a mixing bowl or container, and a funnel. If the formula is made from a powder, an egg beater and a strainer are also necessary. When a quart graduate is used for measuring, the formula can be mixed in it, thus eliminating the need for a separate mixing bowl. To mix an evaporated milk, dextrose and maltose, and water formula, the water is measured first, then the dry ingredient is added and the mixture is stirred until it is dissolved. Warm water should be used to facilitate the dissolving process. After the prescribed amount of evaporated milk has been added and mixed well, the formula is ready to be poured into the bottles. When the formula is made from a powdered milk the prescribed amount of powder is dissolved. The formula should be strained before it is poured to get rid of any lumps that did not dissolve. After the formulas are mixed they are poured into the bottles, nippled and capped, then are autoclaved at 240° F. with 15 pounds' pressure for five minutes. The formulas should be cooled as quickly as possible; if they are allowed to stand at room temperature for too long there is danger of bacterial growth taking place. If possible they should be cooled at room temperature for 15 to 20 minutes and then placed in a pan of cold water until they are cool enough to be refrigerated. After the formulas have cooled they are taken to the nursery in a covered cart and refrigerated.

This is the first of two articles on essentials of the formula room.



The manager's team wins

The Battle of the Work Orders

CRAWFORD N. BAGANZ, M.D. JOHN M. NICHOLS PAUL WEITZ, M.D.

Respectively, Manager, Assistant Manager, and Chief, Professional Services
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WORK orders — requisitions for maintenance, repairs and minor alterations—in a large institution can be either an excellent tool of management or, if improperly controlled, potentially one of the most costly of functions. When requisitions for these services are in excess of available manpower and funds, the problem becomes acute and the need for control imperative.

This hospital of 2000 beds had been functioning for some 20 years when, through a survey in 1948, it was found that there was a hopeless accumulation of literally thousands of work orders which had been submitted over the past years by various individuals in various departments. Some of the individuals who had requested these services were no longer employed here and changing conditions had rendered other requisitions obsolete.

CONFUSION BECOMES CHAOS

It was at that time our policy to have those individuals desiring repairs, minor alterations or installation of equipment submit their requisitions to the engineer officer who, for the most part, approved such work orders and forwarded them to the appropriate artisan. In an overwhelming number of instances, the approval by the engineer officer was done in a perfunctory manner as he had no basis for disapproving them except when the work requested was definitely out of order so far as money, material and labor were concerned. When the submitting official did not obtain what he considered to be prompt or efficient accomplishment of his request, a duplicate or triplicate order was submitted with the notation "Second Request" or "Third Request." This succeeded in converting confusion into chaos and further increasing the backlog of requests.

The survey revealed that with the change of operating officials in various units, such as physicians, nurses and others, many requisitions for minor alterations would undo the work requested by the previous occupants of these positions; that many requests were contradictory, confusing and too often unnecessary.

Each utility shop, such as carpenter, plumber and electricity, had a tremendous backlog of incomplete work orders and, as a result, when new work orders were received the artisan in charge was the sole judge as to which would be completed first. This placed these various individuals in the unfavorable position of being under pressure from various friends, associates and favorites. It also placed the artisan in a position of having to pass on which work orders should be completed for the better over-all operation of the hospital. It was obviously impossible for these employes to know the over-all needs of the patients and the hospital, with the result that, in many cases, the work orders selected for accomplishment were those which the respective operating utility could accomplish with the greatest ease or with the greatest personal satisfaction.

While the survey to this point had disclosed an entirely unsatisfactory condition which resulted in improper use of materials and poor employe utilization, there appeared to be no practical solution to the difficulty. Further study disclosed there were three methods of carrying out work orders:

1. The method of choice on the part of the operating utility. Too often the operating utility would decide arbitrarily as to which work order it would execute and which it would delay purely on the basis of what its opinion and personal regard was concerning the individual requesting the work. If he was popular or highly placed, his request received prompt action. Only too often the case was reversed. An actual example of this procedure is demonstrated in the case of a physician submitting a request for repairs in his unit, and after a long period of waiting noticing the same type of work being accomplished in another unit although the request for his work had been submitted months previously.

2. The method of chronological order. By this method the operating utility attempted to be fair and felt it would carry out all requests in the order in which they were received, regardless of whether the work order required a great deal of time, labor and money, or whether it was a minor repair requiring little time and effort. Also disregarded was the urgency since the operating utility in its desire to be fair felt it was unable properly to evaluate this factor and strictly carried out the request on a first come, first served basis.

An example of this is a physician who took over a ward and needed an

Reviewed in the Veterans Administration and published with the approval of the chief medical director. The statements and conclusions of the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

electric outlet in order to provide the necessary services to his patients. After a period of 60 days it was impossible for him to discharge the responsibility of his specialist duties because of the lack of adequate source of electricity. The physician attempted to investigate this and was informed that he must wait for the completion of this item until such time as all previous requests had been accomplished.

3. The method of importance. According to this method the operating utility felt it should comply with the various work orders and requests on the basis of the importance of such requests. It was at once apparent that the determination as to the relative importance of the request could not be made because of the lack of information concerning the over-all activities on the various wards and buildings.

Experience has amply demonstrated that the method of choice on the part of the operating utility, the method of chronological order, and the method of importance as solutions to the work-order problem were neither feasible nor efficient. Under any one of these methods of handling work orders the attitude soon developed that it was hopeless to comply with all requests and only too frequently the only action taken was to disregard them.

REVIEWED THOUSANDS OF ORDERS

The first step in bringing order out of the chaos was to review thousands of work orders which had accumulated in order to eliminate the outdated ones, the duplicates and the undesirable ones. A committee, consisting of the manager (hospital administrator), assistant manager, chief, professional services, and engineer officer inspected each of these pending work orders, eliminated a great many, and assigned priority numbers from 1 to 3 to the remaining. This was extremely difficult because of the building and room designations, and could not be adequately done without actual inspection of the site. However, it was felt that even with these drawbacks, it was worth a trial, so priorities were assigned and as a result of this, the various operating units were aware of what assignments they were expected to complete and the order of priority.

At this point it was felt that some progress had been made, but a short period of operation in this procedure of assigning priorities revealed that this method was also unsatisfactory and did not lend itself to a solution.

At a conference of hospital administrators at this time, one of the leading hospital engineers in this country frankly admitted that he knew of no other method but to accept the work orders as they were received and "do the best you can." However, when it appeared that we were running into a dead end in our quest for a solution of this problem, there was being developed another important change in the hospital administration which was to become an important factor in solving the problem.

The practice was established of the manager's making rounds on one hospital activity at the beginning of each work day. It at once became apparent that problems of three types were presented to the manager: first, those that dealt directly with patient care and were within the province of the chief, professional services; second, those having to do with minor repairs and alterations to the wards and buildings, and third, those having to do with personnel administration.

The problems arising from the personnel administration were the subject of a previous communication.*

Those problems arising on the rounds having to do with professional services were in many cases solved by having the chief, professional services accompany the manager on rounds. Those concerning repairs and alterations presented a greater problem and resulted in the engineer officer or his designate being invited to participate in rounds in order that problems and needed repairs and alterations which were indicated could be investigated on the spot by these individuals who would have first-hand knowledge of the nature of the problem and, because of the continuing rounds which reach all areas, first-hand knowledge of the over-all problems of the hospital.

In practically every instance, by consultation on the spot with the chief, professional services, and the engineer officer, the decision could be reached as to whether the particular repairs or alterations were desirable, whether funds were available for their accomplishment and whether or not this should be attempted as a hospital-wide practice. Instead of accomplishing hospital-wide alterations piecemeal, under this system by proper management it was found practical to do these on a production basis.

*Baganz, C. N., Fish, L. C., Clayton, R. C.: Supervisory Conferences. Hospitals, 24:49 (August) 1950.

As an example of this, it was felt that with the installation of a new type of nurse's desk it was necessary to have a small shelf for a telephone. Rather than accomplish this on an individual work order from each ward, feasibility of such an installation was acknowledged and these shelves were made on a production basis and installed throughout the hospital according to a plan. Thus it developed that our solution to the problem of the work order had been delivered to us. From this time on, no orders were submitted except to the manager's team with the exception of those of a truly emergency nature.

At the time of the arrival of the manager's team, requests which were accumulated were submitted, investigated and either approved or disapproved on the spot. Work orders were numbered and when supplies were required to complete these work orders the request number was placed on the order and the order number was placed on the requisition. Each work order was assigned a "due date" for completion and prior to the next visit of the manager's team, a report was submitted to this team as to whether the work had been accomplished or not and what progress had been made toward its accomplishment.

A folder was developed for each unit and this folder contained the complete history of what was accomplished regarding each of these repairs and alterations.

RESULTS ARE SPECTACULAR

The results of this procedure have been most gratifying and almost spectacular. The various utility units are no longer flooded with work orders from all areas of the hospital. All requests for repairs or alterations reach these operating units only after the approval of the manager with the full knowledge of the engineer officer and the concurrence in the need by the chief, professional services.

The engineer officer was, in turn, kept fully aware of the work load of the various utilities and these utilities were no longer under the personal pressure of friends and persons in higher echelon or authority. Our experience with this system has demonstrated that it controlled the source of the work order, which we feel is the only manner in which the work order problem can be mastered. Second, the work load was kept under constant surveillance and control consistent with

the capacity of the operating utility. Third, the requesting officials were always told whether their request had been approved or rejected and, if rejected, the reason for the rejection was given. The operating units were always aware of the status of their requests. Fourth, the type of work accomplished in the hospital was that which was most essential and provided the greatest increase in the welfare of the patients.

As might be expected, there was considerable resistance to this plan on the part of the various artisans in the operating utilities after its inauguration. In a few cases there was resentment to what was considered to be a loss of prestige because they were unable to pick and choose the type of work they wanted to do. Continued experience with this system, however, has caused the resentment largely to disappear and the various artisans in the operating utilities now find that they are no longer under pressure, that their work load is more reasonable, that they can utilize personnel more efficiently because planning makes this possible, and that they are expected to do the possible not the impossible.

One disadvantage which was more apparent than real, and which actually proved to be an advantage, was that it required the time of three of the top level officials of the hospital to make these daily rounds. However, since the primary purpose of the rounds was not the problem of the "work order" but to observe the activities in the various areas and furnish advice, guidance and assistance, it was felt that with this solution of the problem of the work order the manager's team was more than justified.

HOSPITAL LICENSING PROGRAM

accentuates the optimum in operating standards

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A STATE licensing agency should perform three main services. The first of these is defining by legislation what constitutes a hospital or a nursing home. Such a service should be very welcome to those institutions that want to provide really good service to patients, just as the licensing of physicians, nurses and other groups is a contribution to the professions licensed as well as to the general public.

The second service the licensing program can perform is the establishment and enforcement of minimum standards of operation. This compels the unethical or substandard institution to raise its level of practice to the required minimum standards or cease to operate. After the licensing program is in effect, persons planning to open a hospital or a nursing home do not go ahead unless they seriously plan to provide a reasonably safe quality of care. In addition, the established minimum standards for licensure serve as an educational guide for all institutions.

The defining of what constitutes an institution by statute and the establishment and enforcement of minimum standards for operation for all institutions coming within the scope of the act are the parts of a total program for good hospital and nursing home care that can be met only by a licensing program.

The third service is to cooperate with the groups concerned with hospitals and nursing homes in their efforts to raise the standards of care and practices in these institutions. A licensing agency will find many opportunities to work with hospital and nursing home administrators and the professional groups concerned with the programs of care for patients in these institutions.

In order for an official agency to provide these services effectively, it must give serious consideration to the goals of its programs and the plan of administration. The following procedures and methods are recommended as basic to good administration of a licensing program:

1. A representative advisory council. In Indiana we have an eight-member licensing council, consisting of four hospital administrators, one physician, one nurse and two ex officio members, one a member of the state department of public welfare, and one a member of the state board of health. The Indiana State Board of Health, through a hospital licensing council, has the responsibility for licensing all general and special hospitals except mental hospitals. The mental hospitals are licensed by the Indiana Council for Mental Health, and the nursing homes are licensed by the state department of public welfare. Our hospital licensing council passes on all applications for licensure, reviews and advises us in regard to all major policies relating to the administration of the hospital licensing program, and considers all serious problems that arise in regard to institutions under the program. Our council has been a great help to us as well as to the hospitals.

2. Treat all applicants with fairness and in such a way that they know they are being dealt with fairly. This procedure should be followed with substandard and borderline institutions as well as with the really good institutions.

A method we have used successfully in Indiana has been to invite the owners or administrators in for a conference with the council when our surveys showed major noncompliances with regulations which the institutions have no plan to meet. In such cases we advise the administrators of these institutions of the points that are not in com-

Presented at the Tri-State Hospital Assembly, Chicago, 1952.

pliance and tell them we will present our report to the council. We further tell them that the council would like a firsthand report from them in addition to ours in order that they can get as complete a picture of the institution as possible. We also point out that the council will want to know from the administrators what plans they have for meeting the regulations.

There have been 74 conferences in six years under our hospital licensing program. These conferences have given the council a better insight into the problems confronting hospitals, and also the persons who have come before the council with special problems have appreciated the consideration afforded them. As a result of this procedure, the council's decisions have been accepted very well even by those whose license applications have been denied.

3. Develop a means for providing the council a graphic picture of each institution which gives pertinent information and requires little time on its part to study. As a means to this end we have evolved an individual profile of each institution, which shows how it complies with each regulation, how it compares in this regard with the average compliance of all other institutions in the same size group, and also the institution's index of improvement from the previous years.

The profiles of the various hospitals are developed as a result of a statistical analysis of the data obtained at the time of the annual survey. The data can also be analyzed for such factors as compliance with the various regulations by size and type of institution. We find that this type of information is of great interest and importance to voluntary groups, such as hospital, medical and nursing associations.

4. Encourage the evaluation of the administration of the licensing program by the institutions licensed. The Indiana State Hospital Association, at our request, has developed a program for the appraisal of our administration of the hospital licensing program. One evaluation was made early in the program, and another is under way at the present time. The evaluation is made by a specially appointed committee of the state association. This committee has prepared a questionnaire which is sent to all hospital administrators asking for their reaction to various procedures followed in our administration of the program and their recommendations for the improvement of the program. After the committee has received and tabulated the completed questionnaires, it meets with us and gives us its recommendations based on its findings. We find these recommendations very helpful.

There are certain steps that need to be taken on a national basis to assist state agencies in developing good, sound licensing programs. These are:

1. Establish the basic principles of safe care which are essential in the light of present medical knowledge, and use these principles as a guide for the development of comprehensive licensing regulations. Concepts of patient care are changing radically at the present time, and while we recognize some of the essential principles of safe care, others are not known.

2. Establish training and experience qualifications necessary for personnel on state licensing agency staffs for hospital survey and consultation work. At the present time, officials in the state agency have no established criteria to use as a guide for the selection of staff for this work.

3. Establish training programs for persons working on hospital licensing programs in order to assist them to measure institutions' compliance with regulations, and prepare them to give effective assistance to operators and personnel of institutions in meeting regulations.

4. Establish national voluntary approval programs for nursing homes comparable to the national hospital accreditation program in order to define and strive for an optimum level of care on a voluntary basis. A licensing program can only establish and enforce a minimum level of care essential for the safe care of patients.

Public Relations Starts in the Cradle

THE Women's Guild of Utah Valley Hospital, Provo, Utah, recently held the second of what will become an annual baby alumni party. The first was held in 1950 but the 1951 party was cancelled because of a polio epidemic.

Invitations were issued to more than 1600 babies born between the time of the 1950 party and the date of the current party. Approximately 300 mothers, babies (and some older brothers or sisters) were present during the party from 3 to 5 p.m. A program of songs, dances, readings and other entertainment was offered. About 25 prizes, donated by local merchants, were offered to holders of lucky tickets. The party was held on the lawn under the shade of apple trees and umbrellas.

At present each baby is enrolled and a miniature birth certificate is sent by the guild announcing the enrollment in the alumni organization. Two "piggy banks" are kept in the hospital by the guild in which contributions can be placed. Appropriate signs tell the story of the banks and how the money is used to purchase new equipment.

We feel that it is an excellent means of promoting good public relations.—JOHN H. ZENGER, *administrator, Utah Valley Hospital, Provo, Utah.*

How to Buy INSURANCE for the hospital

4. LOOPHOLES IN THE INSURANCE PROGRAM

RICHARD C. SLEEPER and DWIGHT W. SLEEPER
Field Engineer and Chief Consultant, Respectively
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IN MANY of the larger and older cities the current building laws provide that buildings of nonfireproof construction if damaged by fire or other peril to as much as 50 per cent of the value or area may not be repaired but must be totally demolished. In other localities the law may not be explicit, but will provide that the building inspector at his discretion may forbid the reconstruction of such a partially damaged building in the interest of public safety. Our observation has been that building commissioners and inspectors are kept aware of the public reaction to the too frequent fires in hospitals, schools, hotels, and other institutions where many persons congregate, and that they have a considerable power to regulate the alteration and repair of buildings which they must be expected to exercise at proper times.

INSPECTOR MAY REQUIRE CHANGES

We cannot predict what may be ahead for any of our readers, or even tell any particular reader what the building laws of his particular area may presently provide, nor what the temper of the building inspector or of the community may be at some time in the future. But surely it will be a matter for prudent management to investigate. However, we can say that, unless otherwise specially provided in the contract, every insurance policy obligates the company to pay only the cost of repairing or of replacing the damage caused by the insured peril less the deduction for depreciation sustained by the damaged property.

Thus it may happen that, in addition to the deduction on account of depreciation, and a further deduction because the insurance is not equal to the warranted percentage of depreciated value, there may be a further loss because of the enforced demolition of the remaining portion of the building which is not considered sufficiently fire-safe. Or, if the building inspector does permit the repair of the damage, he may require the construction of improved fire escapes, or the installation of sectional fire walls with automatic fire doors, or the installation of automatic sprinklers, all of which will be at the expense of the owners, since the insurance company will pay only the cost of restoring the damaged property to a condition like that which existed before the loss.

This situation would be disastrous to many hospital boards that may be burdened already with mortgage obligations and inadequate income, but it will not hurt in the least those boards that have had the wisdom to prepare for such a contingency. For an additional premium, usually 15 per cent of the rates applying to the building in question, the insurance companies will assume the risk of enforced demolition by adding a "demolition endorsement" to their policies, and then will pay for a total loss whether caused by the insured perils or by consequent enforcement of the building laws. This need be done only with reference to buildings of nonfire-resistive construction and only where there is reason to expect or to fear interference with repairing damage.

The insurance against enforced demolition is only a part of the solution because there is still to be considered the increase in the cost of so rebuilding or improving the structure that it will comply with the building laws. The problem here is to get a good estimate of what it will cost to erect a comparable building which will meet the minimum requirements of the law governing such an occupancy, and what it will cost to duplicate the present building in the present type. Then a company must be found which will cover the difference.

In some rating jurisdictions the companies are permitted to attach to building policies a "demolition and increased cost of construction endorsement" for which a 33⅓ per cent increase of rate is charged, and some such endorsements will be so worded that the company will pay the increased cost of superior construction only if the building is totally demolished and rebuilt, which is pretty "tricky." In other cases an endorsement can be obtained which is so worded that the company will pay the increased cost if any superior construction is required, such as fire exits or other fire protection. And it is often possible to get a lower rate for the excess cost of superior construction policy than is charged for the ordinary policy, since there should not be any surcharge in it for demolition and the possibility of being involved in an excess cost loss is less than in the normal policy.

COVERAGE FOR DEMOLITION COST

This discussion will not be technically completed unless we point out that if the demolition clause is added to the building policies and the companies are obligated to pay the assured a total loss, they still are obligated to pay only the full cost of reproducing an identical building, either without deducting depreciation or less depreciation, according to how the policies are written, and this will leave the assured to pay the cost of demolishing the undestroyed portions and of clearing the site ready for the new construction. This can be insured by a special policy in an amount equal to the estimated cost of demolishing 50 per cent of the present structure.

This is the fourth of a series of articles on how to buy insurance for hospitals which began in the July issue of this magazine.

Most business managements recognize that any damage to their buildings or equipment would affect their earnings during the time required to restore the property damage. Depending upon the extent of damage, there may be a total stoppage of business, or a partial interruption, which may extend from a matter of hours to many months, and this may greatly reduce the earnings while still leaving the outgo for nonsuspendable expenses undiminished. Such a catastrophe can be insured at moderate cost.

INSURANCE AGAINST INCOME LOSS

Since many hospitals are nonprofit institutions, many managements have felt that business interruption insurance would be of no value to them. This is an erroneous conclusion, because even if there are no profits to be lost through suspension of services, there will surely be continuing expenses, such as the salaries of essential employes, and there may be necessary expense for heat, light and power, certain types of insurance, interest on borrowed money, and possibly other items; and such a policy will reimburse the management for any loss of profits and for the necessary expenses during the time of interrupted operations and to the extent that they would have been earned had no damage to the property occurred.

The medical director of a large hospital recently stated that if his hospital buildings were destroyed they would be out of business and all expenses would cease, so he would not gain any benefit from business interruption insurance. This, we think, is an oversimplification. In the first place, most fires or explosions only partially damage the property, and are of a nature that temporary or complete repairs can be made soon enough so that most of the employes will be kept on the pay roll and other costs will be only partially reduced, even though there will necessarily be a reduction in receipts. And there may be a necessity for incurring some extraordinary increase in cost to keep the services near normal.

For example, a fire in the laundry might force the sending out of all work to a commercial laundry, thus increasing the expense. An explosion in the boiler room might make it necessary to rent and operate portable boilers in order to provide essential heating, and renting boilers is costly. The destruction of a wing of the hospital might reduce the bed capacity greatly and yet not materially reduce the operating costs. Fires in an elevator penthouse or in an operating room or laboratory or in an x-ray machine might reduce the earning power of the hospital.

A properly drafted contract will provide for paying the assured, to the extent they would have earned had no interruption occurred, its actual losses of net profits and of continuing expenses, plus all authorized extraordinary expenses during the time required with due diligence to restore the damaged building and/or equipment when directly resulting from the insured peril.

The coverage is so well known in commercial operations, and the cost is so moderate, that to suffer a serious loss without the benefit of business interruption insurance might bring strong criticism on the board of directors and the manager. In one case recently studied the cost of such insurance to a limit of $100,000 was only $50 per year, in many cases the income from one private room for a few days. Such insurance has often been a lifesaver to businesses with mortgaged property and the mortgagee is entitled to claim the entire proceeds of the property loss paid by the insurance companies to apply against the mortgage, thus depriving the assured of funds with which to pay the cost of rebuilding; but where there is insurance to pay for the loss of earnings the mortgage is no problem.

BOILER EXPLOSION INSURANCE

Boilers and other pressure containers explode with more frequency, and do far greater damage, than is generally understood by the public. For example, in 1950 nine companies paid losses totaling more than $8,800,000 for such losses and this is by no means the entire story. The fact that such accidents do not happen more frequently and do far greater damage is the result of the expert inspection and testing services which the insurance companies provide for the insured equipment, to discover developing defects and faulty operations before they result in accidents for which the companies must pay. The purchase of pressure vessel insurance is both a loss preventive and loss protection measure.

In spite of all efforts which can be made, damage often occurs. Recently in one plant the night fireman suddenly discovered that the water in the high-pressure boiler had become dangerously low; in his confusion he did the wrong thing with the result that boiler plates and tubes were so badly damaged that it cost $85,000 to repair the boiler. There was no explosion, and that was something to be grateful for, but the management was most grateful that it had purchased the form of policy, and in adequate amount, to cover that loss. Some terrible accidents have resulted from explosion of steam cookers in kitchens and from explosion of steam sterilizers.

A boiler explosion policy provides, first, for periodic inspections of each insured object; second, for payment of the cost to repair or replace any damage to any property of the assured which may be caused by the explosion of any insured object; third, for paying the cost of defending any claim or suit brought against the assured by anyone claiming that his property has been damaged by such an explosion, and, fourth, the company will pay that part of any damages awarded to persons not employed by the assured for injury resulting from such an explosion, which is in excess of the limits of his general liability insurance, but the total liability for any or all of these items will not be greater than the limit of the policy.

While the costliest accidents are those which result from the explosion of boilers and other objects arising from excessive internal pressure, steel boilers and steam jacketed cookers may suffer damage due to collapse resulting from vacuum, or bulging, or the burning of the shell or tubes, involving costly repairs. If the policy is written to provide "limited" coverage, that means that it will pay only for damage done by actual explosion of the boiler, whereas the "broad" form will also pay for these other forms of damage. Cast-iron boilers are also subject to possible cracking and leaking of one or more sections simply because of changes of temperature and the "broad" form of policy will pay the cost of the necessary repair.

FIGURING POSSIBLE DAMAGE

The explosive force of steam pressure at the rupture point of its closed container is terrific. Boilers and heavy objects have been hurled from their base through several walls and floors, or shot up into the air to land hundreds of feet away, involving not only great damage to property of the owner and injury to his employes, but also damage to adjacent property and to the person of others. Fire insurance will

pay for any resultant fire damage, but only the boiler explosion policy will pay for the direct explosion damage.

It is impossible to fortell the extent of damage which may be done by a boiler explosion, but it will be well mentally to start at the location of the object to be insured and think of it as a huge cannon about to fire a shell through your property in the direction which would do the greatest damage, and then estimate what it might cost to repair that damage. You must also consider what other property is within, say, 500 feet of the boiler house and allow for possible damage to any such property belonging to others. If you have large limits in your general liability insurance policy, that should take care of bodily injury claims caused by boiler explosion, so no additional amount need be included in the boiler policy.

COST OF SUCH INSURANCE

The cost of such insurance depends upon the nature and the number of the objects to be insured, the limit of liability, and several other factors, and this can be determined only by consulting the representative of the insurance companies. It can be stated that the higher the limit of liability the lower the cost per thousand dollars, since the cost of inspections remains constant, and the possibility of having to pay the limit of the policy becomes less the higher the limit.

Unlike fire insurance where the policy covers everything not excluded, boiler insurance covers only the objects the hospital elects to insure. Boilers, compressors, pressure containers like air tanks, sterilizers and pressure cookers do explode; revolving objects like flywheels on engines and centrifugal driers in laundries may explode; motors, generators and other electrical equipment may be damaged by short circuits and burnouts. There are numerous other possible causes of accidental mechanical damage, all of which may be covered by insurance on the basis of cost to repair or replace less depreciation, and to cover all or most of them will be expensive.

In our judgment, no property owner or lessee who operates steel boilers can afford not to buy boiler insurance; in fact the law of most states requires that if boilers are not insured by a licensed insurance company then the owner must pay the state the cost of inspecting them, and that cost will be nearly as much as the insurance premium without any indemnity's being afforded in case of accident. Steel boilers should be insured under a "broad" form of policy. Cast-iron heaters even though intended for low-pressure operation can explode if the safety valve or other protective devices should fail, but not with so great force; hence the cost of insurance is low, unless cracking is included; we recommend at least the "limited" form of policy for them. Other pressure containers, such as compressed air tanks, sterilizers, and steam cookers, should also be insured under at least the "limited" form of policy.

We do not recommend insuring against the breakdown or burnout of small motors and other objects which are readily replaceable or not costly to repair, except under conditions related to interruption of earnings. In between the objects which it is essential to insure and those not essential, there will be a wide range of motors, generators, refrigeration equipment, engines and flywheels of varying cost and insurance expense, all of which need to be studied by management, the mechanical superintendent, and the insurance company engineers to determine the relative importance of inspection, insurance and premium.

Interruption of earnings by boiler explosion. Damage caused by the explosion of a boiler can shut down the normal operations of a hospital and interfere with its earnings just as readily as can fire damage. In fact, a relatively small amount of damage may completely shut down the entire plant. For example, the bursting of a tube or the explosion of fuel gases in the firebox or uptake of the boiler may shut down the operation in cold weather and thus make it impossible to maintain essential heat in the hospital buildings.

It is possible to extend the boiler explosion and machinery breakdown policy by endorsement so as to provide a stated number of dollars for each day of total suspension of normal operation, and pro rata of such daily indemnity for partial suspension, for as long as the time required with reasonable diligence to restore the damage, or for the limit of the indemnity stated in the policy. The cost of such insurance will depend upon the limits of daily and maximum indemnity desired, and upon whether the indemnity is to begin at the time of accident, or whether the assured is willing to stand the loss for the first one, two, three or more days, and then be indemnified for the loss of longer duration.

Considering that all hospitals which do not buy boiler explosion "use and occupancy" insurance are assuming all the risks of shut-down from accidents of every sort that can affect their heating and other mechanical equipment, and which they think of as something that can be restored in a few days, this type of insurance may be thought of as catastrophe cover, and may well be bought on the plan which suspends any indemnity for the first five days, and then becomes effective for the duration of the interruption, thus reducing the cost of the insurance considerably.

If the earnings of a hospital are fairly uniform throughout the year the fixed daily indemnity form of boiler explosion use and occupancy insurance for whatever amount the management may want to purchase will be satisfactory. However, if there is much seasonal or other variation in the earnings the "actual loss sustained" form of indemnity may be better, inasmuch as it will pay whatever the loss may be during the time required to restore the damage sustained by the insured object or by other property damaged by the explosion. In this case, the amount of earnings lost will have to be calculated on the basis of what the books show to be the rate of earnings under current conditions and during the same season of the previous year.

WHERE SELF-INSURANCE IS BEST

There are many, many ways by which property can be damaged or destroyed and normal operations and earnings interrupted, with varying effect upon the assets of the corporation, the continuity of employment, and the service to the community. Where the cost of repair can be predetermined and where it will not be serious, self-insurance is indicated, but prudent management must explore all possible channels of disastrous effect and then determine what risks to insure.

It is the obligation of the insurance companies to make the protection and indemnity available under proper and fair conditions. It is the responsibility of the insurance adviser to make sure that the contracts are so written that when the adjuster comes to apply their terms and conditions to the loss there shall be no controversy, denial of liability, or other bar to the prompt and satisfactory payment of the claim.

They Made Hospital History

JOHN and WILLIAM HUNTER - 1

OTHO F. BALL, M.D.
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"The more we know of our fabric, the more reason we have to believe that if our senses were more acute and our judgment more enlarged, we should be able to trace many springs of life which are now hidden from us; by the same sagacity we should discover the true causes and nature of diseases, and thereby be enabled to restore the health of many who are now, from our more confined knowledge, said to labor under incurable disorders. By such an intimate acquaintance with the economy of our bodies, we should discover even the seeds of disease, and destroy them before they had taken root in the constitution." (William Hunter)

MEDICINE and surgery at the time of the Hunters, William and John, had shaken off many of the old superstitions and crude practices but had not attained to the rank of a science.[1] Knowledge of these subjects consisted of isolated facts without systematic classification. Physiology, which treats of the function of the living organism, and pathology, the study of structural and functional changes caused by disease, were quite unknown until revealed in the anatomic schools of the Hunters. "It required genius of the highest order to place these branches of the healing art upon a just and enduring foundation."[1] There has never been any question regarding the genius of either of the Hunters, but pages have been devoted to arguments as to which one of the brothers excelled the other — as though one could ever set up a measure of genius. As Mather[2] has well said:

"Genius is an irrepressible, innate power that asserts its presence in the world even under the most depressing and retractive influences. Genius is something in human nature so mysterious that it with difficulty admits of a precise definition. While ordinary powers advance by slow degrees, genius soars on rapid wings. . . . Undoubtedly they (the Hunters) had genius, but it was so tempered, so overspread with the spirit of industry that there was the just balance, so rarely combined, which gives preeminence among mortals and ranks these gifted men among the greatest of human beings."

John is usually conceded to have been the greater man, yet we must recognize the fact that when John entered the medical field, William, 10 years older, was already well established as an anatomist; furthermore he was John's first teacher. Also John lived and continued to work 10 years after William's death, building upon the knowledge they both had acquired. Certainly everyone will admit that John could scarcely have risen to the height he did without his brother's teaching and help. Many a man with an exceptional mind has failed to climb above the normal level because he has had no opportunity to enter the field in which he might have excelled.

In many important ways the Hunters were alike; in numerous ways, less important, they differed. "Both were in the most true sense of that time benefactors of the human race. Both labored, not only without public encouragement but in the face of the greatest difficulties and the most chilling and discouraging inattention, in teaching anatomy and physiology and the best principles of pathology upon a foundation solid and durable; and both devoted in the most disinterested manner the pecuniary means which the exercise of their profession supplied, not in procuring expensive luxuries, not in occupying large estates and erecting magnificent mansions, but in providing subsequent generations the means of anatomical instruction, upon the same solid foundations on which they had already built."[3]

William Hunter, born in 1718, was the seventh child of John and Agnes Hunter, who lived in Long Calderwood, 7 miles from Glasgow; his brother John was their tenth and last child, born in 1728, when the father was almost 70 years old. James, three years older than William, joined his brothers at William's school of anatomy and showed promise of becoming great in the field of "physic," but he died early of tuberculosis.

The greatest difference between William and John was in their educational background. William was a scholar. He entered the University of Glasgow at the age of 14, remaining there for five years, and in that time changed his mind about entering the ministry. He studied medicine with the illustrious William Cullen for three of the happiest years of his life (1737-40) and in the winter of 1741 studied in Edinburgh under Alexander Munro.

William Hunter was proficient in the Latin and Greek languages and studied the ancient writers. He was a brilliant and forecful lecturer and

JOHN HUNTER
1728-1793

writer. John Hunter, on the contrary, had almost no schooling. After his father died when John was 10, his mother was evidently unable to keep him in school. John stated later: "When I was a boy I wanted to know all about the clouds and the grasses and why the leaves changed color in the autumn; I watched the ants, bees, birds, tadpoles and caddis worms. I pestered people with questions about what nobody knew or cared anything about." The statement that when John, at the age of 17, joined his brother-in-law, a carpenter in Glasgow, he could neither read nor write is no doubt an exaggeration. But he disliked books and rarely read any. When William died, he left a library of 12,000 volumes which cost him between £3000 and £4000 and contained the classics and other foreign literature of all previous centuries. John's library at his death sold for £160.

However much John disdained books, preferring the knowledge that comes from personal observation and experimentation, he realized his lack of formal education as he grew older. Whereas his bedside and clinical demonstrations were enthusiastically given and drew many students about him, his anatomic and surgical lectures, however valuable, were heavy, filled with uncoordinated details that bored his listeners.

John Hunter's letters and his great works are often ungrammatical, the spelling is incorrect, and his meaning is sometimes vague. He disliked giving the lectures although he considered them basic in teaching the medical student. Usually when starting a new course of lectures, he found it necessary to take laudanum just before the first few classes, to quiet his nerves. John has been accused of coarseness in his lectures. Often he expressed himself forcibly rather than politely; for instance, when discussing a case of gunshot wound, he described the ball as having "gone into the man's belly and hit his guts such a d—d thump that they mortified."[9]

WILLIAM HUNTER
1718-1783

It is astonishing, therefore, how a man whose education began at the age of 20 could rise so rapidly and to such great heights in so short a time. "His career affords an illustrative example of a man of great intellectual prowess triumphing over early defective training, and marching onward step by step, despite vast obstacles, to the highest pinnacle of human greatness."[2]

Volumes have been written on the lives of these famous brothers. The Hunterian lectures, begun in 1814, occurring first annually and later biannually, have left nothing unrevealed regarding the vicissitudes and efforts of these men. Only a brief sketch of their lives can be given here.

WILLIAM WAS SURGEON'S PUPIL

After his winter of study in Edinburgh, William Hunter entered the service of Dr. James Douglas, as tutor to his son and as a dissector. Under the influence of Douglas, William was entered at St. George's Hospital as a surgeon's pupil, studying under Frank Nicholls. There he attended the sick and diligently dissected the dead.[4] While under Munro's instruction at Edinburgh he had "learned with his ears, not his eyes," for only one body was available in the six-month lecture course, with a fetus added for study of the nerves and blood vessels and a dog for surgical operations.[4] When he gave a course of lectures before a society of naval physicians, he was able to demonstrate his lectures in anatomy and operative surgery by personally prepared specimens.

His anatomical school, which he opened in 1746, became the most celebrated in London. It was at this time that he began his excellent dissections, which formed a large part of his noted museum. He believed that an extensive knowledge of the human body in health and disease is the "only sure foundation for rational pathology and practice."[4] He took nothing for granted. Only after careful examination did William Hunter draw his cautious conclusions. He stated: "Some physiologists, gentlemen, will have it that the stomach is a mill; others that it is a fermenting vat; others again, that it is a stewpan; but in my view of the matter it is but a stomach, gentlemen, a stomach."

It was while William Hunter resided with Smellie that he became attracted to midwifery and decided gradually to give up his surgical practice to devote his time to obstetrics. He became preeminent in this field. In 1764 he was made physician-extraordinary to her majesty Queen Charlotte, wife of King George III.

TOOK OVER WILLIAM'S CLASSES

In the meantime, John at 17 was learning cabinetmaking while assisting his sister's husband, but when the brother-in-law failed in business three years later John asked William to make him his assistant in dissections. William welcomed his brother and immediately recognized his remarkable skill in dissecting the human body delicately and accurately. In the second winter, John was able to take over William's class in dissections. In 1755 William made him a partner in the school.

In the summers of 1749 and 1750 John had attended the lectures of William Cheselden at Chelsea Military Hospital, and in 1751 at St. Bartholomew's Hospital had studied under the famous surgeon, Percivall Pott. Persuaded in 1755 to enter St. Mary's Hall, Oxford, he made but a short stay. William had hoped that with some formal education John would become a physician rather than a surgeon, at that time not a highly rated profession.

John, then 27 years old, quickly left the halls of learning, declaring they tried to make an old woman of him there, but he had cracked their schemes like so many vermin as they came before him.[5] He entered St. George's Hospital in 1754, as a surgeon-pupil and became a house surgeon two years later.

His brother James' death from tuberculosis and his own poor health following an attack of pneumonia caused him to seek a change from his arduous labors, for like William he worked from early morning until late at night. He obtained an appointment as staff-surgeon in an expedition of the army to Belle Isle in the Bay of Biscay in 1760 and in 1762 served with the English forces in Portugal. During his service he gained information for his noted treatise on gunshot wounds. He used

his spare time to begin his research into comparative anatomy and physiology by studying the digestion of snakes and lizards during hibernation and also the faculty of hearing in fishes.

While John was in the army, William had taken on a new assistant, William Hewson, who later became his partner in the lecture courses. In 1770 Hewson was succeeded by W. C. Cruikshank. Now 35 years old, without means except a small pension, John, on his return, began his surgical practice and opened his own course of lectures. He had to compete with Pott of St. Bartholomew's, Bromfield and Hawkins of St. George's, and Sharp and Warner of Guy's, all established surgeons with good hospital appointments.

BLACK MARKET IN CADAVERS

In 1745 the old United Company of Barbers and Surgeons had been dissolved and private dissections were no longer forbidden by law.[6] However, bodies were hard to obtain, and not until the time of the Hunters was instruction in anatomy through dissection made generally possible. That both William and John obtained their many cadavers through the black marketeers of the time — the resurrectionists — is not denied. In fact, John was accused of cultivating friends among the despised body-snatchers.

The interesting, not too elegant story is told of John's possession of a giant's body. The giant named O'Brien, 8 feet tall, was aware of John's love for abnormal specimens and of his watchful eyes, and when his health began to decline arranged, for the price of £200, that when he died his body should be concealed until a lead coffin could be built, after which it should be dropped into the ocean, thus escaping dissection.

John missed the giant from his accustomed spot and learning of the arrangements, offered through a servant a higher reward if the fishermen would drop the body as agreed, then bring it up and deliver it to John.[2] The men haggled with him until he paid £500 for the nefarious deed. When he received the body he hastily boiled it in a great brass kettle, which later laid around for many years at Earl's Court and was finally sold as junk for 30 shillings.[7] O'Brien's skeleton rests in the Hunter Museum.

Unlike William, John only slowly developed a practice. It was 11 years before his income reached four figures, and he delayed his marriage until that time.

John Hunter's appointment to St. George's staff gave him the privilege of taking house pupils. It has been said[2] that virtually everyone in the generation following his who became noted in surgery in Europe had attended his lectures. Among them were John Abernethy, Edward Jenner, Henry Cline, Everard Home, Astley Cooper, John Thomson, James Macartney, James Wilson, Edward Coleman, Thomas Chevalier, and Philip Syng Physick of the United States.[1]

His intimacy with Jenner continued for the rest of his life although Jenner had refused the suggestion to set up a school of anatomy with him. Although John Hunter had encouraged Jenner to continue his studies of the vaccine pustule which he had observed on the hands of milkers, all of whom escaped smallpox contagion, it was not until three years after Hunter's death that Jenner made his discovery public.[8]

When Philip Physick was brought to Hunter (1780), the father of the youth looked around and inquired what books his son would need. Hunter pointed to three bodies lying on the dissecting table and replied tersely that they were the books he would use. Physick proved so apt a student that Hunter tried in vain to persuade him to remain as his own assistant. It has been said that those who "walked the hospital" with John Hunter carried his spirit of inquiry and love of truth through England and to the New World. Many became teachers in new medical schools: Sir Astley Cooper at Guy's, Cline at St. Thomas', Abernethy at St. Bartholomew's, Sir Anthony Carlisle at Westminster; others like Physick carried his message to America.[6] From 1746 to 1783 John Hunter is said to have delivered the most complete course of anatomical lectures ever given in London and in between times enriched the science of medicine by some of the most valuable contributions ever received.[4] Baillie considered him the best lecturer in anatomy that ever lived.

While William and John Hunter built up their noted practices and compiled their vast museums, their great contributions to the practice of medicine were being recognized by the organized medical societies. Many honors were heaped upon them. William became physician-extraordinary to Queen Charlotte, wife of George III, in 1762 and John became surgeon-extraordinary to the king in 1776. They were made fellows of the Royal Society of London in 1767, John becoming a member three months before William. Both received diplomas to practice from the Corporation of Surgeons, William in 1747 and John in 1768, and both were fellows of the Royal Society of Medicine and the Academy of Medicine of Paris (1780, 1783). William became president of the Royal Society of Physicians (1780) and John was made a fellow of the Royal College of Surgeons of England, and of the Royal College of Surgery of Ireland.

William received an honorary degree of doctor of medicine at the University of Glasgow (1750) and was made professor of anatomy to the Royal Academy of Painting and Sculpture (1768). John received the Copley Gold Medal from the Royal Society (1787), was made deputy surgeon general of the army in 1786 and surgeon general and inspector three years later. He was further honored by being made a fellow of the American Philosophical Society.[1]

This is the first section of the article on the Hunter brothers. The second part will appear in the November issue of this magazine.

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It's Time the Towns Paid Their Debts

to the hospitals that serve them

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THE hospitals of Massachusetts are reimbursed a maximum of $12 a day for the care of old-age assistance and welfare cases. The average cost per patient day is now in the neighborhood of $20 for the hospitals of this state. The hospitals of Massachusetts are contributing to the towns and cities that they serve an average of approximately $8 for every day's care rendered to the patients for which the communities are responsible. It is obvious that the voluntary hospitals are subsidizing our local governments to a large extent.

Interested in viewing the other side of the picture, that is, how much are the communities contributing to the hospitals, I sent a questionnaire to 124 voluntary hospitals in our state, requesting information as to the aid that each hospital receives from its local government in the way of public services and use of town facilities.

Study of the 116 replies indicates that the matter of assistance between government and hospitals is strictly a one-way street. A great majority of the communities are unaware of the financial contribution of the hospitals and recognize no responsibility to reward the hospitals for the dissipation of their assets on the community's behalf.

The survey showed that out of 116 hospitals in the state only 11 receive free water from their communities. Another 10 buy water at a reduced rate. However, 94 hospitals pay the same rate as the corner tavern pays.

Even in the matter of garbage collection, which most householders take for granted, 48 of the hospitals must pay to have garbage removed. The other 68 hospitals apparently have a magnanimous local government and receive free garbage collection. Although the question was not asked, eight hospitals indicate that they sell their garbage at a profit.

Municipal Assistance in 116 Massachusetts Voluntary Hospitals

1. Does your city or town furnish water?
   - Free.....11
   - Reduced rate.....10
   - Full rate.....94
2. Does your city or town provide garbage service?
   - Free.....69
   - Reduced rate.....0
   - Full rate.....2
   - Not at all.....46
   - (8 hospitals sold their garbage)
3. Does your city or town provide rubbish removal?
   - Free.....56
   - Reduced rate.....1
   - Full rate.....8
   - Not at all.....51
4. Does your city or town do your snow plowing?
   - Free.....50
   - Reduced rate.....0
   - Full rate.....2
   - Not at all.....64
5. Can you call upon your city or town government for help for miscellaneous matters such as driveway repair, tree spraying, use of trucks, etc.?
   - Yes.....13
   - No.....71
   - Limited.....32

Out of the 116, 60 hospitals have to pay for rubbish removal. One of the 60, however, states that the community removes the rubbish at a reduced rate.

In the matter of snow plowing, which it would seem towns and cities should perform out of an elementary sense of responsibility to citizens, the communities show a distressing lack of interest. It is the custom in most communities to give priority to the plowing of main highways, the area around the police and fire stations and sometimes the routes to the hospital.

However, the survey indicates that in most communities the town fathers feel that they have done their part if the roads are plowed to the hospital driveway; it is then the hospital's responsibility to maintain egress to the street. As far as most communities care, the mother in labor must trudge through the deep snow from the street to the hospital. Only 50 of the 116 hospitals get free plowing. The majority of these indicate that plowing is limited to the main driveway and does not include other entrances, drives or parking areas. Two hospitals say that their communities would plow their driveways but would charge them for doing so. Fifty-five

per cent state that their communities do not participate in snow removal in any way.

The final question asked was: Can you call upon your city or town government for help in such miscellaneous matters as driveway repairs and tree spraying? This kind of assistance could be of great benefit to most hospitals and would be a negligible expense to the communities. However, 71, or 57 per cent, of the reporting hospitals receive absolutely no such aid. Thirty-two hospitals receive limited assistance, and only 13 of those replying can depend upon their local government for real help.

Study of the questionnaires brings out the fact that there is no consistency between the various departments of a local government—that is, in some communities there may be rubbish removal but no garbage collection—indicating that the generosity of a community is probably dependent on the head of the particular department concerned and is seldom a matter of town policy. In one community reporting, one hospital receives free water and another hospital in the same town pays for it. I suspect that benefits received from the community are related to the pressure the hospital is able to bring on town or city officials.

I should like to see hospitals treated the same as any other business in town is treated and be charged the regular commercial rates for the various services received, if in turn the local government would treat the hospital as it does any other vendor it deals with and pay the regular charges for the services received. But as long as communities are permitted by state law to purchase hospital services below cost, they should at least recognize their indebtedness to the community hospital and do what is easily and cheaply within their means in helping reduce our costs of operation.

The big lesson to be obtained from this survey is that here is another public relations field on which we had better get busy. Our town fathers need to be told that they are indebted to us and should start paying off.

You, too, can understand

What Hospital Workers Want

HARVEY SCHOENFELD
Assistant Director
Montefiore Hospital
New York City

EVERY organization has personnel policies. Although an organization may not have printed policies, they exist nevertheless—being implied in the orders, decisions or opinions of the administration. Unwritten policies, however, are dangerous to both management and employe because frequently they are misinterpreted.

Personnel policies, when intelligently conceived, are the foundations of sound personnel relations. Based on the objectives of the institution, they also should reflect the basic desires of the worker. They must be so developed that they always can serve as guides to action in the solution of personnel problems. They also must be made understandable at every level, since they set the tone of the hospital and affect the morale of the worker.

Morale is of vital importance to us as administrators because the quality of service to the patient is always in direct proportion to the level of employe morale. Morale is something that cannot be obtained by order or encouraged by logical argument; neither can it be bought for a price. We have often made the mistake of assuming that high wages and short hours are what workers want most from their jobs. And when wages have been raised and hours shortened, some administrators have been amazed and discouraged by a continuation of the discontent; they are unable to explain satisfactorily to a hounding governing board why the staff is still sulking.

It is interesting to note, however, that this lack of understanding of what the worker really wants is not confined to management. Many employes themselves are unaware of what is needed to make them satisfied in their jobs. This apparently illustrates a well established principle of human behavior, *i.e.*, it is difficult for a person to identify in clear and unmistakable terms the forces that underlie his feelings and his actions.

Every impartial study of what employes want from their jobs has shown that many things other than high wages and shorter hours are considered important. You may doubt that these points are applicable to your institution. Yet in the last five years I have seen these unsatisfied desires form the basis for serious employe grievances. Experience has clearly demonstrated the marked difference in the effects of a personnel policy predicated on basic desires of workers, which after all are the desires of all average human beings, and a personnel policy based on the needs of the moment, or expediency. The poor results of the latter are classical and can be prognosticated.

Members of the Association of Hospital Personnel Executives in New York City have been cognizant of these employe desires and motivations. Many of them have had the opportunity to develop or suggest revisions in personnel policies for their institutions. Each policy generally has been scrutinized in the light of its effect on the morale of the employe and the needs of the hospital. Where discipline is fostered by a policy it succeeds only when its fairness is obvious to all. Otherwise covert opposition on the part of the employe results.

At hospitals with which I have been associated an attempt has been made actually to put the personnel into per-

sonnel policy. The development and revision of such policy are made by an employes' personnel policies committee, composed of representatives at every level of the hospital organization. By preliminary orientation of the committee in the objectives and financial abilities of the hospital, we have been able to develop broad policies that have been acceptable to the administrator and the governing board. In several instances, the members of the committee have recognized traditional abuses in sick leave benefits and overtime and have emphatically recommended policies tending to restrict and eliminate such abuses. Out of such committees have come realistic and workable policies that have contributed in large measure to higher employe morale.

The written policy that is formulated in consultation with those who must live under it and that is followed consistently by the administration engenders in the employe a powerful sense of faith and security in the management of the hospital. Again, policies relieve administrators of the burden of continually making new decisions on similar problems and searching their memories as to what they did before.

Personnel policies, to be effective then, must consider the worker's desires within the framework of the hospital's objectives. These desires, so well known to social scientists, may be listed as follows:

1. *A steady job.* Because of the nature of human illness and the trend toward greater hospital use (albeit, shorter stays), it is possible to state this policy firmly and thereby capitalize upon it as a means of attracting efficient workers. The general policy for this might read: "It is the intention of the John Doe Hospital to provide continuous employment to all permanent members of the staff consistent with our objectives of the best possible care to the patient at the lowest possible cost."

2. *Opportunity for advancement within the organization.* This evidences itself in the promotion and training policies, which might read as follows: "It is the intention of the John Doe Hospital to promote from within the ranks. We shall offer all opportunities for advancement on the same or higher levels to qualified personnel of this hospital before seeking outside talent." In the training of employes: "Employes shall be trained to accomplish their jobs in the best possible manner and for succession to positions of a higher level in keeping with the ever changing needs of the John Doe Hospital for qualified supervisory personnel in all departments."

3. *The desire for recognition of accomplishment.* This should be reflected in the policy on rating of employes. It might read: "Employes' accomplishments shall be reviewed and classified at stated intervals. Such classification shall be the determining factor in transfers, promotions and downgrading."

4. *Equitable salaries, wages and hours of work, and reasonable and safe working conditions.* These, of course, are reflected in their respective policies, which might read:

A. "To pay equitable salaries and wages in keeping with the financial conditions of the hospital. It shall be based on an evaluation of the job in relation to the same or similar work in the hospital and the competing labor market and shall be set up in scale form to recognize the learning pattern of people."

B. "Hours of work shall be reasonable and in keeping with those of other hospitals in the community as well as the requirements of continuous 24 hour service to the patients of John Doe Hospital."

C. "Working conditions shall at all times be maintained at a level consistent with the safety and health of employes and effective service to the patient."

These are some of the most fundamental policies that might be used by administrators of hospitals as guideposts. Other specific policies based on the general statement and the attitude of the governing board would include such policies on: sick leave benefits; vacation allowances; hospitalization benefits; methods of wage payments; orientation; discipline, and accident reporting.

With the technics cited previously any hospital organization can develop an effective approach to personnel problems. The present-day high cost of labor and the rapidly diminishing source of labor supply for hospitals make it imperative that concrete personnel policies be established. Once established, the development of a personnel program, using effective technics, can result in many economies.

VOLUNTEER ACTIVITIES

All for the Children

The pediatric play area at Hartford Hospital, Hartford, Conn., will soon be operating full scale. There are inside and outside areas with a volunteer supervisor in charge. The inside play area has attractive tables, chairs, toy shelves, and bookshelves. An awning is being erected over the outside area, which also has furniture and play equipment. Funds to complete this play center have just been voted by the women's auxiliary board from proceeds of a barber shop quartet concert.

Small patients who cannot leave their rooms or wards have not been neglected. The auxiliary is providing a record library to suit the varying taste of youngsters. Thirty-six outlets in the pediatric department permit the relaying of these records.

This active auxiliary will also appropriate funds for three additional resuscitators for use in the delivery rooms of the maternity building.

Another project is the installation of six new lavatories in South Building at a cost of $26,000. These will contain nine toilets, seven showers and six sitz baths. The financing of this project will be spread over three years.

Memorial to a Friend

Last year Mrs. Catherine Delano Grant, the founder and long-time president of the Friends of the Deaconess, died. One year later the Catherine Delano Grant Nurses Scholarship Fund began reviewing candidates for its first scholarship. The sum of $11,000 had been raised for the purpose. Half of it came from Mrs. Grant's friends outside of the New England Deaconess Hospital in Boston; the remainder by Friends' projects, contributions and a gift from the Junior Friends. The annual Boston Pops concert yielded $1,200, $200 of which came from donated flowers sold at the concert by the Junior Friends.

About People

Administrators


Emmett R. Johnson

Emmett R. Johnson is the new administrator of Western Baptist Hospital, Paducah, Ky., which will open next summer. Mr. Johnson, who received his bachelor's and his master's degrees in hospital administration from Northwestern University in 1952, served an administrative residency at Medical Center Hospital, Tyler Tex., and an administrative externship at Baylor University Hospital, Dallas.


Mark Berke

Mark Berke has resigned as administrator of the Albert Einstein Medical Center, Southern Division, Philadelphia, to accept the position of director of Mount Zion Hospital, San Francisco, succeeding **Dr. J. A. Katzive.** Dr. Katzive's appointment as director of the health services division of the United Auto Workers (C.I.O.) was announced in the July issue of The MODERN HOSPITAL. Mr. Berke also has served as assistant director of Mount Sinai Hospital, Cleveland. He is a member of the American College of Hospital Administrators and the American Hospital Association.

William H. Morrison, formerly business manager of Friends Hospital, Philadelphia, has been appointed administrator of West Jersey Hospital, Camden, N.J. Mr. Morrison is a member of the American College of Hospital Administrators, the American Hospital Association, and the Hospital Association of Pennsylvania, as well as the Philadelphia Hospital Association.

James V. Devine has succeeded **Edna M. Hayward, R.N.,** as administrator of Wesson Maternity Hospital, Springfield, Mass. Miss Hayward resigned to become administrator of the Benjamin Stickney Cable Hospital, Ipswich, Mass. Mr. Devine, formerly administrator of the Webber Hospital, Biddeford, Me., took his hospital administration residency at Malden Hospital, Malden, Mass. While there he studied at the Institute for Hospital Administration at Brown University. Miss Hayward, a graduate in nursing from New England Baptist Hospital, Boston, served at the Boston Lying-In Hospital before going to Wesson Maternity as administrator in 1926. She was recently elected a fellow of the American College of Hospital Administrators.

Sister Carlos assumed her new duties August 13 as administrator of the Hotel Dieu, New Orleans, succeeding **Sister Celestine,** whose appointment as administrator of St. Thomas Hospital, Nashville, Tenn., was announced in the September issue. Sister Carlos formerly was associated with De Paul Sanitarium, New Orleans, where she had served as director of the affiliate school of psychiatric nursing and assistant administrator since 1946. In 1951, she took a course in hospital administration at St. Louis University.

Richard W. Blaisdell, the newly appointed administrator of Peninsula Hospital now under construction at Burlingame, Calif., has held the position of assistant administrator of the University of California Hospital and assistant business manager of the University of California Medical Center in San Francisco since 1950. A graduate of the course in hospital administration from the University of Minnesota, Mr. Blaisdell served his administrative residency at San Jose Hospital, San Jose, Calif.

Robert E. Toomey has become administrator of North Country Hospitals at Gouverneur, Canton and Alexandria Bay, N.Y., succeeding **Tracy F. Storch.** Mr. Storch's appointment as executive assistant for services and supplies at New York Hospital, New York City, was announced in the September issue. Mr. Toomey, who completed a course in hospital administration at Columbia University, served an administrative residency with the Hospital Council of Greater New York and Roosevelt Hospital, New York City. Upon completing his residency he remained at Roosevelt Hospital until his recent appointment.


Allen J. Perrez

Allen J. Perrez Jr. has been appointed to the newly created post of assistant to the administrator of Rochester General Hospital, Rochester, N.Y. He has been associated with the hospital as credit manager since 1949. A graduate of the school of nursing at Rochester State Hospital, Rochester, he has served as a nurse at St. Joseph's Hospital, Elmira, N.Y., and at St. Mary's Hospital, Saginaw, Mich. He also has been night supervisor at Rochester State Hospital. He is a member of the Rochester Regional Hospital Council's purchasing committee.

Harold E. Wetzel, who resigned as administrator of the Neblett Hospital and Clinic, Canyon, Tex., is now administrator of Everglades Memorial Hospital, Pahokee, Fla.

John C. Imhoff, who completed his administrative residency in hospital administration at City Hospital, Cleveland, has been appointed administrative assistant at City Hospital. Mr. Imhoff is a graduate of the University of Chicago's program in hospital administration.

Arthur B. Paulson, formerly assistant administrator in charge of accounting and purchasing at Brockton Hospital, Brockton, Mass., has been appointed administrator of Jordan Hospital, Plymouth, Mass.

James C. Heidenreich is the new assistant to Administrator **John Paplow** at Santa Barbara Cottage Hospital, Santa Barbara, Calif. Mr. Heidenreich, who completed his administrative resi-

(*Continued on Page* 186)

3 GREAT ADVANCES

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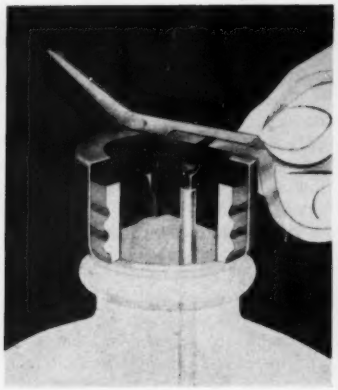

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Conducted by Raymond P. Sloan

Why BLUE CROSS COSTS are what they are

WILLIAM S. McNARY
Executive Vice President
Michigan Hospital Service
Detroit

WHEN the word "costs" is mentioned these days in relation to Blue Cross, two problems are brought to mind at once. These two problems are in the limelight at present because of the extremely competitive conditions prevailing in the voluntary health insurance field.

Problem No. 1 is the fact that different Blue Cross plans find it necessary to charge different rates for different patterns of benefits, and that, moreover, different Blue Cross plans charge different rates for approximately the same benefits.

Problem No. 2 is the fact that Blue Cross rates have been going up and are still going up.

TWO PROBLEMS ALWAYS WITH US

I should like to deal with these two problems first, primarily, perhaps, because they are always with Blue Cross and I am, therefore, a little self-conscious about them, but also because they loom large in the voluntary health insurance field. Blue Cross critics, professional Blue Cross detractors of the pie-in-the-sky variety and hardheaded insurance salesmen are all equally vociferous in presenting these two problems as outstanding disadvantages of Blue Cross protection.

They are disadvantages, too. Every Blue Cross representative can testify to the fact that he has to meet these arguments at least once a day, and many times a day if a rate raise should happen to be on the agenda for his particular plan.

Yet here is a seemingly curious contradiction. Were it not for these two problems or disadvantages, Blue Cross today would probably be "Little Business" instead of it being, as it is, "Big Business." Moreover, Blue Cross would be going backward not forward. It would be facing the fate of becoming just another forgotten noble experiment.

The reasons these two problems, despite the fact that they are handicaps, have played such an important part in building Blue Cross, are rather obvious. What we are up against here are really not shortcomings but the anticipated and inescapable results of operations based on two principles that are fundamental to the whole Blue Cross effort and philosophy.

The first principle is that Blue Cross rates must everywhere be honestly and realistically related to regional and local differentials in hospital costs and charges. We know that wages are not the same all over the country. Living costs are not the same. A $10 a day room in an Alabama hospital may be a good private room; $10 may not even pay for a ward bed in Washington or New York. These differentials are facts. That these differentials show up in Blue Cross rates is not a reflection upon Blue Cross but testimony to the fact that Blue Cross rates are honestly geared to the economics of each community.

Not only do costs differ from region to region, from state to state, even from city to city in the same state, but habits differ in regard to utilization and types of services, and so do the sizes of families. Blue Cross rates must reflect all these variations.

The second principle is that Blue Cross benefits must be provided, to the extent circumstances permit, in a package that meets the realities of today's medical practice. Medical care cannot be bought by the pound or by the yard. It cannot be bought piece by piece as one may buy a set of expensive dishes. When a man is sick, he needs a medically dictated minimum quantity of hospital services. Blue Cross must come as close as possible to assuring its members this minimum package. As the cost of this package goes up, whatever the causes may be, Blue Cross rates must follow suit. As new services and new drugs are introduced by developments in medical science and medical and hospital practice, Blue Cross rates must reflect the resulting increases in cost.

BASED ON REALITIES

We in Blue Cross are not seriously disturbed by the disadvantages we suffer because we knowingly and deliberately base our operations and our rates upon the realities of regional and local cost differentials. That we are criticized for this is only too true. When a national corporation wants uniform benefits at uniform rates for all of its employes from coast to coast, the differences in Blue Cross rates and practices create a real headache. However, this is a problem we are solving without changing the sound and honest principle from which it stems.

The second problem—of persistently increasing rates, owing to increasing

This article contains some amplification of the remarks delivered before the Columbia University Conference on Current Problems in Administrative Medicine, May 15, 1952.

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hospital costs—is equally real and must be faced. A good part of this problem cannot be separated either from the contemporary history of medical and hospital progress or from our current economic developments. Commercial insurance companies have the same trouble as Blue Cross whenever they attempt to offer benefits that approach full coverage. Let me cite examples:

1. A manufacturing concern in Michigan which employs some 12,000 people purchased a complete group insurance package a couple of years ago which provided hospital benefits patterned closely after Blue Cross coverage. When the first year ended the group was presented with a bill for some $40,000 per month more for the next year. Well authenticated rumor has it that the insurance company lost $600,000 on the group in the first 12 months. A substantial part of this loss was incurred because the hospitalization rate first quoted was lower than the Blue Cross rate; when raised, it was well above the Blue Cross rate.

THEY CAME BACK

2. Three years ago a number of groups controlled by one Detroit union with some 1500 members left Blue Cross for a brand new commercial insurance plan which offered benefits similar to Blue Cross at comparable rates. During that three-year period Michigan Blue Cross has had two rate increases—so has the commercial plan. Three weeks ago the president of the union phoned to ask us to take them back as soon as possible. They had just been notified of a third substantial premium boost. We said we'd be happy to welcome them back to Blue Cross but that we could not guarantee our rate either. "Never mind that," he said, "we still want Blue Cross."

The commercial insurance companies are not concealing these facts. The *New York Journal of Commerce*, on April 29 of this year, reported that J. Henry Smith of the Equitable Life Assurance Society of New York told a meeting of life insurance actuaries in Washington that loss ratios for his company have been going up in recent years, particularly the loss ratios for hospital and surgical expense insurance. In some instances, he said, the loss ratios have been above the levels contemplated in the premium rates.

Among the factors underlying the upward trend in loss ratios, according to the *New York Journal of Commerce*, Mr. Smith cited increases caused by premium reductions, policy and claim liberalizations, costlier medical practices and diagnostic and therapeutic technics, experimentation with marginal types of groups, increased utilization of medical facilities when insured, duplication of coverage, and effects of inflation on costs. Stanley Gingery of Prudential, addressing the same meeting, confirmed the increase in claim rates for his company for employes' and dependents' hospital and surgical benefit coverage.

Obviously the problem of the rising costs of voluntary health insurance is affecting the commercial companies as well as Blue Cross. The public is not happy about this, of course. Hospitals and doctors are being criticized every day because it costs so much to be sick. Blue Cross is criticized on the grounds that its liberal benefits and the liberal interpretation of its certificates encourage abuse. Let us recognize that some of the harsh things being said about hospitals, doctors and Blue Cross are probably true. Some hospitals are not operated as efficiently as they should be. Some Blue Cross patients are not discharged as soon as they should be, or as soon as they would be if they were not protected by Blue Cross. Some Blue Cross patients are needlessly given expensive drugs when less expensive medication would do just as well. There is some truth in all of these charges. Knowing hospitals as I do, and knowing Blue Cross as I do, it is my belief, however, that these charges only touch on the real source of the danger we face in the field of voluntary health insurance.

In my opinion the following factors are responsible for all but a small fraction of the increased cost of voluntary health insurance:

1. Inflation.
2. Competition for personnel which has forced hospitals to raise wages and salaries from their very low pre-World War II status to levels which are now comparable to those prevailing in industry and business.
3. Health education and health propaganda.

The first factor—inflation—is something that we in the early days of Blue Cross—back in the 1930's and even in the early 1940's—never dreamed of. What we worried about in those days was what would happen to Blue Cross in the event of another depression. During my first six years in Blue Cross I never heard anyone warn us about the dangers of inflation. I am not sure I know which is the worst—the danger we all knew and feared, or the danger we did not dream of and now face.

The second factor in rising hospital costs is little understood by most people. One of my responsibilities as a young man, during the depths of the unlamented 1930's, was to make up the annual budget for a good sized university hospital. I remember only too well the large cuts I recommended in all salaries, including my own, of course. I also recall with what I may describe as uncomfortable vividness my reluctance to budget maids at $30 per month and general duty graduate nurses at $50 per month. These hospital employes were getting very little even during the prosperous Twenties. That made it all the harder to decrease their already pitifully small wages. However, it had to be done if the hospitals were to stay open.

DEMAND IS INCREASING

We have already touched upon the problem of inflation. There is the problem of the increased demand for hospital services, the phenomenally increased demand we have faced during the last 10 years. This demand has forced hospitals to compete with industry and business for its personnel. To meet competitive wages and salaries hospitals have had to increase their wages and salaries not 50 per cent, not 100 per cent, but as much as 300 and even 400 per cent, in order to dig themselves out from the abnormally low wage levels that prevailed in the 1930's. The real trouble is not that hospital costs have risen so much during the last seven years, but that they had so far to go under the pressure of circumstances to reach prevailing levels.

In other words, a good portion of the increase in hospital costs is the result of the need imposed upon the hospital to meet competitive wage and salary standards. Percentagewise these increases look terrific; in actuality they are but a climb, and a long-delayed climb, to the average.

It is, therefore, useless to compare today's hospital costs with those of 10 years ago. On the basis of wages and salaries paid 10 years ago hospitals could not begin to recruit or hold the more than 1,000,000 full-time employes they need nationwide to provide the services asked of them. Since hospitals have begun to pay wages comparable to wages paid by industry

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and business, increases in hospital costs have followed the pattern laid down by the general inflationary trend.

The third important factor in rising hospital costs is that of health education and health propaganda. As far as I am concerned this is the fact that requires our most careful attention. I believe in health education. I believe the public is entitled to all information on medical developments. Also, I accept the fact as an inescapable part of our calculations, that the more attention people give to health, the more they are educated to the business of timely care, the higher our national medical bill will become. I say we can cope with this problem. There would be no room for us in the prepayment field if we could not take in our stride the progressive extension of our medical knowledge.

IRRESPONSIBLE REPORTING

What I am concerned about is the increasing volume of irresponsible reporting that is passed out as health information. A few weeks ago, for instance, a prominent Michigan newspaper published a story under a two-column head, which read as follows: "Neurosurgery Enters Cerebral Palsy Fight." The story below the headline revealed that the surgery was experimental; that no positive conclusions as to its value could as yet be drawn, and that the surgery had been tried out without success, really, on only a certain type of victim. Nothing definite, nothing promising. The story revealed that there are an estimated 12,000 cerebral palsy victims in Michigan alone. Since Michigan Blue Cross covers about 40 per cent of the people, we are safe in assuming that as many as 4800 of the cerebral palsy victims are probably covered by Blue Cross and Blue Shield. I cannot say how many of these possible 4800 victims may, as a result of this story, become candidates for the ineffective surgery propagandized through the press. And this surgery offers neither promise nor hope.

How much does it cost to hospitalize a cerebral palsy victim for such an experimental operation? I cannot say. But here we face the most serious problem confronting voluntary health insurance. Can we cope with this kind of journalism?

The May issue of *Medical Economics* shows equal concern about the same problem. To quote the magazine: "On February 21 last, the medical profession had the privilege of being let in on the secret of a new and important therapeutic agent at exactly the same moment as the general public. Most doctors were not appreciative.

"The drug, of course, was isonicotinic acid hydrazide, developed simultaneously by Squibb and Hoffmann-LaRoche. Front page newspaper disclosure of test results of these companies' products set off the greatest hullabaloo in the field of tuberculosis since Robert Koch developed tuberculin in 1890.

"Within two weeks of the announcement, the original couple of hundred experimental patients in four hospitals were reported to have increased to 10,000 in 300 hospitals. Orders for the drug poured in from all over the world."

The magazine goes on to point out that the claims for the drug were hasty, to say the least. But the newspaper stories conveyed the impression, and I quote *Medical Economics* again, that "Inexpensive pills would soon be available to cure the disease; even the conservative *New York Times* had said so.

"As a matter of fact, the *New York Times* had said so, in effect, but with qualifications. Other papers qualified the story, too; and prominent chest specialists warned against overconfidence. But the words of caution got mostly back page space. The headlines spelled an unqualified story of hope."

Within two weeks the number of patients hospitalized for treatment with this drug jumped from a couple of hundred to an estimated 10,000!

In the same issue, this magazine reports on the way Krebiozen was introduced to the world as a cure for cancer. The original claims for Krebiozen were moderate, but let us see how it was introduced to the public, according to *Medical Economics:*

"There were few other signs of moderation, however, in the commotion surrounding the unveiling of Krebiozen in the French Room of Chicago's Drake Hotel on March 26, 1951. The meeting was called by Dr. Ivy and he presided. It was graced by the presence of a newcomer to scientific circles: State's Attorney Boyle.

"Also there were a score or two of persons interested in cancer research. Several of them were surgeons, a few of them were clinical investigators themselves, but more were program administrators. There were assorted press and radio representatives; plus two or three unwanted business promoters. . . . A brochure was handed out—'Krebiozen: An Agent for the Treatment of Malignant Tumors. . . .'"

Comments *Medical Economics:* "While no press agent could have dreamed up a finer publicity stunt, the results of the meeting were unfortunate." In one week the University of Illinois got 11,000 appeals for the drug, which could not be filled. One man flew from Wilmington, Del., to get some.

DEVELOPING PUBLIC HYSTERIA

I could go on citing many such examples; a little research would list hundreds more. Their cumulative effect is developing something like a chronic public hysteria about "wonder" drugs and quick cures. This hysteria is being fed in several ways. I could not begin to count the number of individuals, organizations, foundations and public agencies that are engaged in raising money in order to encourage research directed toward controlling the many diseases that plague mankind. Each of these agencies has its own high-powered public relations departments or agents. These people raise both fears and hopes. What returns are we getting in relation to what the effort is costing the public? We know that tens of millions of dollars are being poured into our medical institutions by these efforts. We know that this money is inflating the cost of equipment, is inflating the cost of supplies and drugs, and that it is inflating the cost of scarce personnel. What are the returns besides and beyond the fact that these efforts are helping set the stage for the type of "Cure-of-the-Day Club" publicity I have cited?

It is my contention that we should do everything possible, publicly and privately, to advance medical research. I believe, however, the time has come for us to take serious inventory of what is happening here, if we are to develop our prepayment programs in an orderly fashion, progressively expanding their benefits to meet the sound demands of new medical developments.

It would be a relatively easy matter for us to explain to the members of Michigan Blue Cross that the new X drug brought relief to 20,000 Blue Cross members during the past year who previously had no remedy at all for their ailment, and that this new development upped our payments to hospitals by $1,000,000 above the cal-

culations on which we had based our rates. I could explain that with confidence, with pride and with sound statistics. But it is another matter to explain, much less cope with, the waste of subscriber funds resulting from activities which exploit the hopes of the sick and the unfortunate.

None of us in the field—neither the doctors, the hospitals, the prepayment plans nor the medical institutions in general—stand to benefit from this type of free-for-all health propaganda that retards medical science and tends to reduce medical research to a sort of medieval alchemy.

As far as Blue Cross is concerned, we cannot but take the stand publicly that this irresponsibility in the field of health journalism constitutes one of the serious dangers we face.

We are all familiar with the publicity given the so-called wonder drugs. I do not know whether they are doing all that is claimed for them. But I do know that they have increased Blue Cross costs by many millions of dollars and have played a part in recent Blue Cross rate raises. We have learned that many wonder drugs are only "90 day wonders" but the cost of the temporary "cures" obtained is a permanent cost. The medical profession and the ethical drug manufacturers can well devote more attention to the control of publicity and attendant premature demand for unproved pills and potions.

To summarize:

Voluntary health insurance can cope, I am confident, with the rises in costs which result from the need to increase hospital wages and salaries to competitive levels. This is a problem we can understand and explain. It is a problem that holds the promise of stabilizing itself.

Voluntary health insurance can cope, I am confident, with rises in costs resulting from the general inflationary situation. This is again a normal problem that can be explained.

Voluntary health insurance can also cope, I am confident, with the current tendency to abuse it. The hospital, the doctor and the patient can be educated to understand that they cannot abuse Blue Cross without sooner or later hurting themselves. There will always be some abuse. We can devise methods, as we are trying to do right now, to cut this abuse to a tolerable minimum.

But I am far from confident that voluntary health insurance can cope with the most expensive disease of all —the infectious superstition spread by our yellow health journalism that there are cures for everything and that we can abolish all diseases. No society can assume the economic responsibility for the popular spread of such a superstition. Rate making is reduced to a farcical adventure with the unknown when a few headlines in the newspapers, or a blown up magazine story, can destroy all your calculations.

I do not have the answer to this problem. I do know that the time has come for all of us in the health and medical field to get together on it. By all of us I mean the hospitals, the doctors, Blue Cross, Blue Shield, the government agencies, the foundations, the universities—to see what can be done to put our educational efforts on sound ground. Unless we can get more sanity and discipline into the field of health education and health journalism, the health propaganda being spread may betray us into something much worse than a sea of socialization—it may betray us into a society of sanitariums.

From the point of view of administrative medicine, the rising costs of voluntary health insurance pose the following problems:

1. Greater efficiency in the hospital, particularly in regard to planning of installations and supply as they affect utilization of manpower. Now that the hospital has to compete with industry for labor, it must recognize the need for introducing concepts of efficiency to make the competition effective. Hospital costs are too high to allow of any waste.

2. Methods of control must be established and methods of education must be introduced to curb the abuse of Blue Cross. Increases in Blue Cross costs, regardless of whether the hospital profits from them or not, affect the hospital's relationship with the public.

3. Immediate and intelligent attention to the most serious evil of all—the evil of irresponsible exploitation of public credulity. It is before this evil that all of us involved, the hospitals, the medical profession and Blue Cross, will have to prove ourselves competent to manage the prepayment mechanisms for hospital and medical care that have become our trust. We must revamp our whole educational program, we must develop new concepts of ethical behavior.

These are the three major problems, as I see it, confronting administrative medicine in the United States.

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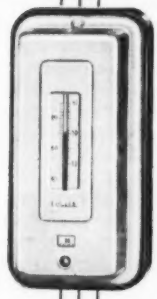

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If you want good

CLINICAL LABORATORY SERVICE

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DAVID F. BURGOON
Laboratory Consultant
Division of Medical and
Hospital Resources
Public Health Service
Federal Security Agency

CLINICAL laboratory service in hospitals has shown a continual expansion in recent years. More nearly accurate and reliable laboratory tests, increased emphasis on preventive medicine, and the gradual realization that physicians in rural communities need the same diagnostic aids as physicians in cities are factors contributing to this growth.

This increased utilization of the clinical laboratory emphasizes the necessity for more serious consideration of the needs of this service. No longer can the laboratory remain the hospital's stepchild when facilities for a community medical care program are being planned. Because availability of personnel, types of facilities, and services offered by the hospital laboratory vary from one community to another, each hospital presents an individual problem based on the medical pattern of its own community.

Intelligent planning requires that everyone concerned with providing adequate hospital services understands what the clinical laboratory is—its functions, its physical requirements, and its personnel needs.

LABORATORY FUNCTIONS LISTED

The functions of the clinical laboratory may include any or all of the following: to provide information to assist the physician in diagnosing, treating and preventing diseases; to assist in training programs, and to conduct research. Generally, training programs and research are confined to hospitals of 200 beds or more, because of limited clinical material, personnel and equipment found in most hospitals below this bed level.

The clinical laboratory is composed of various departments, established on the basis of similarity of technic, type of specimen to be examined, or knowledge of a particular science to be employed in testing. These laboratory departments are: histology, urinalysis, hematology, biochemistry, bacteriology and serology. The morgue and necropsy units, although not physically located within the laboratory wing, are considered part of the laboratory service. Basal metabolism tests, electrocardiograms and electroencephalograms are usually performed by laboratory personnel, and facilities for conducting these examinations may be included in the laboratory wing. Clinical photographic laboratory and medical illustration are usually the responsibility of the laboratory.

Some departments require auxiliary facilities to maintain a complete working unit. The bacteriology and serology departments, for example, utilize a great deal of glassware in performing their tests. Therefore, a central glass washing facility should be located in the immediate vicinity of these departments.

The bacteriology department also requires culture mediums and sterile glassware for its work; therefore, facilities for these activities should be placed close to the department. Both the serology and the bacteriology departments use animals for conducting their tests so a small unit for housing animals, with facilities for operations and cage sterilization, should be conveniently located. Animal quarters for breeding purposes and exercise should be in a separate building constructed for that purpose.

The blood bank in general hospitals with fewer than 100 beds is part of the hematology department. Larger hospitals require separate facilities for this activity. An average of six blood transfusions per bed per year is made at present, with an anticipated future annual demand of 15 per bed. The location of the blood bank unit depends on whether the surgical service or the laboratory service is administratively responsible for its operation. When the surgical staff operates the blood bank, the unit is usually located near the operating room suite and recovery rooms. It would be wise to investigate the local American Red Cross blood program before investing in the equipment needed for the blood bank.

LOCATING THE MORGUE

Although the morgue and necropsy and specimen museum are operated by laboratory personnel, they should be located away from the traffic of patients and visitors, preferably in the basement. They also should be con-

venient to the elevator, with an isolated exit to the service yard, if possible, for the use of undertakers.

Consideration of the flow of work in the laboratory is most important for the proper management of its units to achieve efficient operation. Laboratory facilities must be planned in relation to the other medical services of the hospital. The type of laboratory examinations to be performed, the volume of work, and the departments that will utilize the laboratory should be considered in determining location and space requirements.

Chemistry, serology and urinalysis laboratories will receive specimens from the nursing units and outpatient department. The surgical department will send specimens to the histology laboratory for pathological examination. On-the-spot, rapid examination of surgical tissue can be performed in a "frozen section laboratory" located in or near the operating suite. The histology laboratory will also receive specimens from the necropsy room. The photography unit will receive patients and specimens from the laboratory, surgical, medical and outpatient departments. Basal metabolism tests and electrocardiograms sometimes are made at the bedside; at other times the patient may be sent to the laboratory. Electroencephalograms are made in their own unit.

SELECTING THE PATHOLOGIST

It is recommended that the pathologist who will be responsible for the administration of the laboratory be brought into the hospital planning program in the very beginning. The pathologist selected should be a qualified physician with at least five years of laboratory experience, and should be certified by the American Board of Pathology. Because of his specialized knowledge of laboratory procedures, of required equipment, and of space necessary to perform tests, early consultation with him will be invaluable.

Medical technologists, under the supervision of the pathologist, are responsible for the specific work of the laboratory. Too often laboratory work is done by improperly trained individuals who are vested with responsibilities beyond their ability. This tends to lower the confidence of the medical staff in reports made by the laboratory and can lead to results disastrous to the patient's welfare. Technicians should be eligible for the Registry of Medical Technologists sponsored by the American Society of Clinical Pathologists. This requires two years of college and graduation from a 12 months' course in an approved school for medical technologists.

All laboratory workers contribute to the functions of the laboratory, and the extent varies with the practice of the individual laboratory. Examinations performed should be based on the number of laboratory workers rather than on the number of medical technologists. Estimates on the number of examinations which each laboratory worker can perform in a year vary from 3000 to 7000. Teaching, research and outside requests account for the wide divergence in numbers of examinations performed per worker.

In addition to medical technologists and the pathologists, laboratory helpers, stenographers and janitors are required.

"A study of 120 hospitals doing from 9600 to 765,000 examinations indicated approximately this ratio of personnel: physicians: technicians: helpers—1:5:1; and janitors: stenographers—0.5 to 1. On the average, in such a group, seven to eight laboratory workers would perform 35,000-40,000 examinations per annum. . . . The examinations per patient per day ranged from 0.23 to 2 with a mean of 0.86. It is probable that this mean is high, as some laboratories receive material for examination from clinics and the outside. It is estimated that the figure 0.75 would be more representative."[1]

The increasing use of the laboratory service has required that it be assigned space in an area in keeping with the importance of the functions which it is to perform.

The facilities must be planned in relation to the other medical services of the hospital. The type of laboratory examination to be performed, the volume of work, and the departments that will use the laboratory should determine the location and space requirements. It is rare, indeed, that the laboratory is given more space than is needed. Flexibility and possible future expansion should always be kept in mind. For this reason it is recommended that the laboratory be located in a separate wing or adjacent to space which can be easily converted for its use if necessary.

[1] Williams, G. L.: Laboratory Operations Should Be Standardized, Hosp. Management, March 1948.

The laboratory should be on a lower floor, accessible to the inpatient area, to the medical staff and to outpatients. Since specimens from the necropsy and operating room also will be taken to the laboratory for examination, it should be easily accessible to those departments.

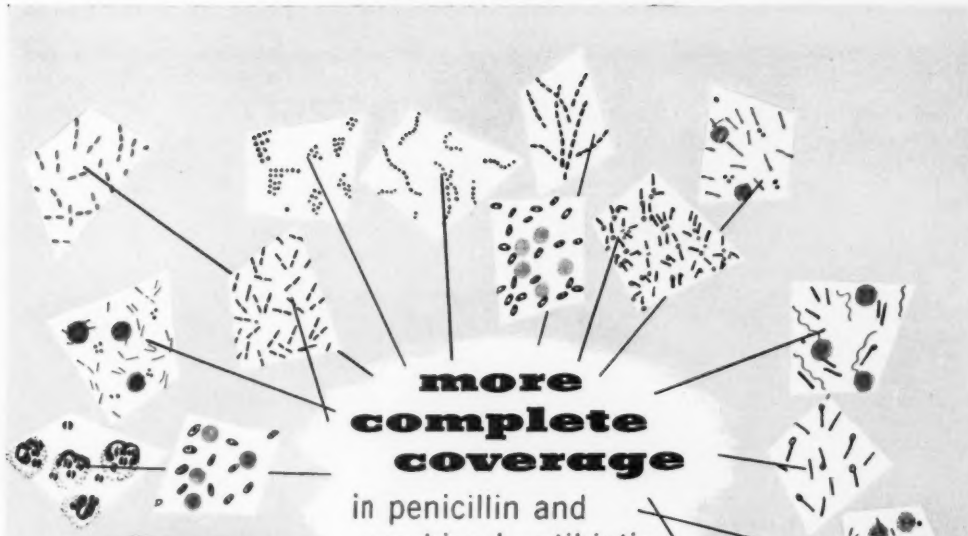
SPACE ASSIGNMENTS

The amount of space assigned to the laboratory service will depend on the size and type of hospital in which it functions. Laboratory facilities in hospitals of 50 beds and under ordinarily consist of one room in which urinalysis, hematology, limited bacteriology, serology and chemistry procedures are performed. In the 100 bed group, more room is required for these laboratory procedures so that services, such as sterilizing, glass washing, and preparing culture media, are performed in separate facilities. The 200 bed general hospital is ordinarily the starting point for departmentalization of the laboratory. The bacteriology and serology laboratory examinations may be combined in one unit, with a general laboratory unit provided for hematology, urinalysis, chemistry and blood bank procedures. When the bed capacity of the hospital is greater, it becomes necessary to provide separate units for each of the departments which are necessary for complete laboratory service.

Office space for the full-time pathologist and secretary should be located within the laboratory wing so that the pathologist can be in close contact with his staff for supervision and consultation. It is desirable in teaching hospitals and research laboratories to provide office facilities for department heads.

There is no hard and fast rule for determining space requirements for various size hospitals; each must be considered an individual problem. However, it is well to keep in mind that adequate working area is important in attracting and retaining desirable personnel and in maintaining a high quality of work. Allowing 4.5 square feet per hospital bed will provide an estimate for the minimum area required in general hospitals up to 500 beds. This does not include walls, corridors or space for basal metabolism tests, electrocardiograms, or electroencephalograms; necropsy facilities also are not included in this estimated area.

Equipment requirements are based



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on the methods used, the types of examinations performed, the volume of work and the number of personnel employed. The pathologist should be responsible for the equipment needs and should be consulted when equipment requisitions are prepared.

Equipment guide lists for 25, 50, 100 and 200 bed general hospitals are available for distribution.[2] These lists indicate equipment needs for the *average* hospital and should be used for reference only; adjustments can be made in consultation with a qualified pathologist to fit the needs of a particular situation.

The quality of equipment varies, and so will equipment costs. Estimates have been made for 25, 50, 100 and 200 bed general hospitals.[2] These averages based on 1951 prices are:

	25	50	100	100
Laboratory				
Group I*...	$1571	$3459	$5202	$8717
Group II and III.....	$2204	$4233	$6283	$9212
Morgue and Necropsy				
Group I*.....		$5129	$5129	$7079
Group II and III.....		$ 316	$ 484	$ 565

*Installation costs are not included.

Modern scientific instruments are vital to the laboratory. Accurate, dependable laboratory reports cannot be made with poor equipment. Hospital administrators should familiarize themselves with laboratory equipment and its use so they can appreciate the need for adequate equipment to provide good quality laboratory service. Good equipment soon pays for itself.

NORTH LIGHT IS BEST

Natural lighting should be used to the full extent. North light is preferable because of its uniformity, without direct sun. Microscopic work is particularly difficult where glare is present. Fixed equipment, such as wall cabinets, refrigerators and centrifuges, can be placed away from windows and artificial light can be used, if necessary, to supplement the natural light. Portable lights with extension cords on the floor and work areas should be avoided. They are hazardous.

Finish materials for the laboratory areas should be selected on the basis of the type of work done in each area and the kind of wear that may be expected.

The floor of the laboratory should be resilient, smooth and acid and stain resistant. Greaseproof asphalt tile, rubber tile or linoleum could be used. The floor of the glass washing and sterilizing room should be easy to clean, nonslip and resistant to heavy traffic.

The walls should be coated with waterproof paint. They should be glazed or have a similar finish to a point above the splash or spray line, and should be without cracks to avoid harboring roaches and ants.

The use of standard manufactured units is recommended for work bench installations, because of their flexibility in meeting changing needs. However, it is important to know exactly what tests will be done in a particular area in the laboratory so that the proper unit will be used. Where sedentary work is to be performed, ample leg room must be allowed. The usual height of work benches used in sedentary work is 30 to 31 inches; for standing work, 36 to 37 inches. Wall units are 30 inches wide and center units are 54 inches wide. The minimum space between work benches or fixed equipment should be 3 feet 6 inches; the maximum, to eliminate needless walking, should be 5 feet.

Small cup sinks and staining sinks may be built into the unit at convenient points to avoid the necessity of using the large laboratory sink.

Counter tops may be of soapstone, wood (birch which has been acid-proofed), stainless steel, treated fiber, composition stone or heavy battleship linoleum.

Wood is quite satisfactory for general use. In areas for glass washing and sterilizing, stainless steel, soapstone or a similar type of material is recommended because of the large amount of water and heat present.

No discussion on the clinical laboratory would be complete without some mention of the mechanical and electrical problems peculiar to this department.

The provision of utilities (waste, cold water, hot water, gas, vacuum, compressed air, distilled water and electricity) is a complex problem in designing the laboratory. The piping and wiring should be easily accessible so that time and money can be saved in making repairs or changes in any existing arrangement.

Placing the vertical utility lines alongside the structural columns, which are located 16 to 20 feet apart in the exterior walls, seems to be the most direct and economical solution to the problem. This eliminates exposed piping in the ceilings and the cost of a dropped ceiling if the pipes are to be hidden. The vertical risers are available for connection to horizontal runs, yet concealed behind removable metal panels at the piers. Dividing the vertical laboratory utilities into three groups and alternating them in consecutive piers will reduce the width of the piers.

Acid resistant piping should be used for waste lines. Laboratory sinks of soapstone or corrosive resistant materials manufactured for this specific use are preferred.

AIR CONDITIONING DESIRABLE

Air conditioning is desirable for the laboratory because it obviates the necessity for opening windows. This is especially true in a bacteriology department where air-borne bacteria are a source of contamination. For the same reason the sterile room or cubicle should be provided with mechanical ventilation. Similar provisions are helpful in the culture media, sterilizing and glass washing rooms where odors and heat from the autoclaves and ovens are likely to make working extremely unpleasant in hot weather.

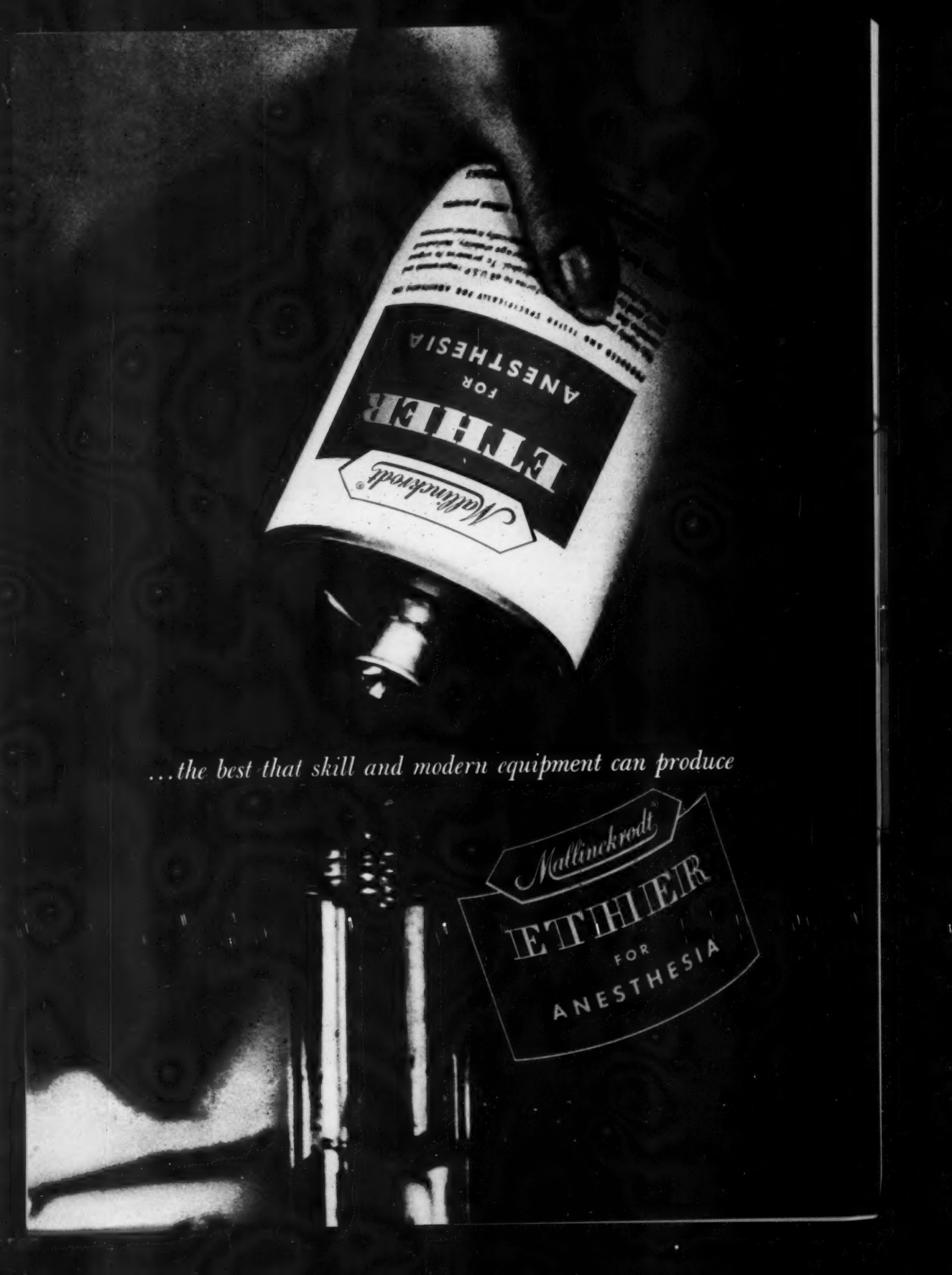
The electrical requirements should be studied carefully in order that an adequate supply be furnished to the laboratory. Sufficient outlets in the work area are often overlooked. Wall mounted switches for room lighting should be used where practicable in preference to pull switches to reduce maintenance. Protection against overloading should be furnished by either automatic circuit breakers or fuses.

More complete and technical information on these problems is given in "State Public Health Laboratory."[3]

The planning and designing of the clinical laboratory in the hospital have been neglected to such an extent that many hospitals today are facing overcrowded working conditions and a poorly functioning laboratory service. The increasing demand for the coordinated hospitals system, with emphasis on more nearly adequate diagnostic service, should be an incentive for a more careful consideration of the function and requirements of this rapidly growing service in the hospital.

[2]Division of Hospital Facilities, Public Health Service, Federal Security Agency.

[3]Material prepared by the Division of Hospital Facilities, Public Health Service, Federal Security Agency. American Journal of Public Health, January 1950.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Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

THE ANTIBIOTICS: Pharmacodynamics and Principles of Therapy

I. PENICILLIN AND STREPTOMYCIN

THE antibiotics are specific chemical agents, produced by living microorganisms and capable of destroying or preventing the growth of certain other microorganisms. This phenomenon of antibiosis was first observed by Pasteur and Joubert, 1877, when they noted that cultures of anthrax were slow to develop when contaminated with bacteria of the air. The therapeutic potentialities of this fact became apparent only with the historic discovery of penicillin by Fleming in 1929, which later completely revolutionized the treatment of a variety of infectious diseases amenable to penicillin therapy and initiated the search for similar agents with broader antibacterial spectrums.

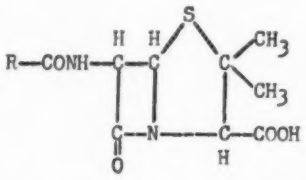
During the past decade hundreds of antibiotics have been discovered, isolated, purified, screened and tested for therapeutic efficacy. Only a relatively small number of these have survived clinical trials. Most of the antibiotics are derived from molds and other bacteria. To date chloramphenicol is the only one of these which can be produced synthetically on a practical basis.

It has been aptly stated that the antibiotics are the "bread and butter" of general practice. In spite of the life-saving properties of these "wonder drugs," they have resulted in an all too frequent indiscriminate use and a complacent attitude toward certain important infectious diseases. They are frequently employed in subtherapeutic quantities, for ailments in which they are completely without effect and in the absence of any verification of a sensitive infectious agent. For the most part this attitude stems from an indifference toward or a lack of fundamental information regarding the basic pharmacology, clinical applications, side effects and limitations of the antibiotics. It is proposed to discuss some of these factors in the present review, with the realization that a detailed analysis of all of the therapeutically established antibiotics is outside the scope of this discussion.

PENICILLIN

Penicillin is the oldest and best known of the antibiotics employed clinically. It was originally derived from a mold, Penicillium notatum. While small amounts have been prepared synthetically, it is commercially available only from natural sources.

Chemistry. Naturally occurring penicillin is not a single substance but is produced in several forms. The basic structure of the penicillins is as follows:



General Formula for the Penicillins

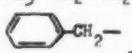
Variations in the prosthetic group R- are responsible for the identifiable types of penicillin designated as penicillin F, dihydro F, G, K and X.

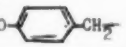
The —C—N group is thought to be
O

essential for antibiotic activity, for when this group is modified, *e.g.* as by hydrolysis to form penicilloic acid, the antibacterial activity is greatly diminished or completely lost. In the presence of mineral acids or alkalis the penicillins are changed into penillic acid, a dicarboxylic acid of the basic structure which is devoid of antibiotic activity. All of the penicillins form salts with sodium, potassium and similar cations as well as types of salts with basic amines owing to the presence of the carboxylic group. The potassium salt and the sodium salt are the most stable and are most frequently employed. Procaine penicillin is more stable and much less water-soluble (only 0.7%). As a rule the organic esters of penicillin are relatively ineffective when administered parenterally but are somewhat effective locally. Recently, however, the diethylaminoethyl ester of penicillin G in the form of the hydriodide has been shown to be quite effective following intramuscular injection. The blood levels and duration of effect are thought to be comparable to those achieved by an equivalent amount of procaine penicillin. Unlike

Penicillin F, R = 2-pentenyl-, $CH_3—CH_2—CH=CH—CH_2—$

Dihydro F, R = n-amyl, $CH_3—CH_2—CH_2—CH_2—CH_2—$

Penicillin G, R = benzyl, 

Penicillin X, R = p-hydroxybenzyl, 

Penicillin K, R = n-heptyl, $CH_3—CH_2—CH_2—CH_2—CH_2—CH_2—CH_2—$

age	no. subjects examined	no. with scurvy	% with scurvy	no. white subjects	no. white with scurvy	no. negro subjects	no. with scurvy
0-15 da.	360	0	0	174	0	186	0
16-30 da.	90	1	—	41	1	49	0
1 mo.	96	0	0	48	0	51	0
2 mo.	90	2	2.2	54	2	36	0
3 mo.	69	3	4.3	31	3	38	0
4 mo.	79	2	2.5	35	1	33	1
5 mo.	73	12	16.5	25	3	48	9
6 mo.	53	11	20.8	19	5	34	6
7 mo.	54	10	18.5	22	7	32	3
8 mo.	40	5	12.5	18	2	22	3
9 mo.	36	10	26.1	12	4	24	6
10 mo.	41	5	12.2	16	0	25	5
11 mo.	40	3	7.5	12	0	28	3
12-23 mo.	177	3	—	68	1	109	2
Total	1303	69		546	29	757	40

PREVALENCE OF SCURVY

SCURVY

is more common than many think

Histological examination* of bone structure in 1300 infant post mortems revealed that scurvy occurred more than 10 times as frequently as is usually shown by clinical diagnosis. The most susceptible age is from the fifth through the eleventh month, with approximately 17% of infants exhibiting the histological signs. Over half of the children with scurvy had never received supplemental vitamin C. How easy to prevent, when Florida citrus is so rich in vitamin C content — so convenient, so economical, and so pleasant to take!

** Bull. Johns Hopkins Hosp. 87:569, 1950.*

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ORANGES • GRAPEFRUIT • TANGERINES

the other forms of penicillin, this agent is reported to cross the blood-brain barrier with ease and to have a special affinity for lung tissue.

Pharmacology. Penicillin is pharmacologically inert in that even greater than therapeutic doses have no effect on normal functions. It is rapidly absorbed following oral administration but requires about five times as much as the parenteral dose in order to obtain comparable blood levels. This is due to the fact that penicillin is partially inactivated by acid hydrolysis in the stomach. It is inactivated when administered rectally by coliform organisms which elaborate an enzyme, penicillinase, that rapidly destroys penicillin. When crystalline penicillin is administered intravenously it is practically all eliminated from the body within about three hours. An intramuscular dose of this form of penicillin, *i.e.* 50,000 units, reaches a maximal blood level within about 10 minutes, which is maintained for about two hours, and then gradually declines. More than 50 per cent of injected penicillin is eliminated in the urine in a biologically active form. In severe renal insufficiency the blood levels are maintained for a much longer period following a single dose. More than 80 per cent of the penicillin eliminated in the urine is a result of direct tubular excretion, the remainder being eliminated through glomerular filtration. Owing to the rapid rate of elimination of crystalline penicillin, various procedures have been devised and various forms of penicillin have been prepared specifically designed to maintain a high blood level following a single dose. Among these are the following:

1. Intramuscular administration of crystalline penicillin at intervals of two to three hours. This procedure is undesirable because of necessity for frequent injections and the frequent trauma.

2. Constant intravenous infusion of crystalline penicillin. Phlebitis may be a complication of this mode of administration which is now used only in patients moribund from infection.

3. Continuous intramuscular infusion of the potassium salt of penicillin G through a plastic tube. This method is especially effective in treating localized infections such as osteomyelitis.

4. The administration of caronamide (4'-carboxyphenylmethane sulfonanilide) or benemid simultaneously with parenteral penicillin therapy. These agents effectively block renal tubular excretion of penicillin, thereby maintaining a higher and more prolonged blood level. It might be pointed out that caronamide itself is not excreted by the renal tubules and probably acts here to inhibit the enzyme systems operative in the tubular excretion of penicillin. Benemid probably acts by the same mechanism of enzyme inhibition.

5. Pencillin in oil and beeswax designed to decrease the rate of absorption following intramuscular injection. This preparation has fallen into disrepute owing to the high incidence of local foreign body responses to the vehicle.

6. The procaine salt of pencillin G, usually suspended in an aqueous medium with a stabilizing and a dispersing agent. This form of pencillin is slowly absorbed from an intramuscular site of injection and produces a therapeutic blood level lasting from 24 to 48 hours following a single dose of 600,000 units.

7. Procaine penicillin G (micronized) in oil with 2 per cent aluminum monostearate. Three hundred thousand units intramuscularly of this preparation will produce therapeutic levels for 96 hours.

8. The diethylaminoethyl ester of penicillin G in the form of the hydriodide. Similar to procaine penicillin as regards absorption and duration, it produces a higher cerebrospinal fluid level.

9. Other forms are penicillin for inhalation, U.S.P. (contraindicated in bronchial asthma and in patients known to be sensitive to penicillin); penicillin ointment, U.S.P.; penicillin tablets, U.S.P., for oral administration; penicillin troches, U.S.P., for local application to mucous membranes of the throat.

Standardization. Although penicillin is now a pure chemical compound, available in the form of stable salts, the potency and quantity are indicated in terms of units defined and established when this antibiotic was known only as a variable crude mixture of the several types of penicillin and estimated through bioassay procedures. One unit was defined as the amount which formed a zone of inhibition 24 mm. in diameter around a cylinder in an agar plate inoculated with a susceptible strain of Staphylococcus aureus. The international units of pure penicillin G in the form of its sodium salt is now defined as 0.6 of a microgram. Thus, 1 mgm. of this preparation is equivalent to 1667 such units. The arbitrary international unit based upon a specific amount of pure penicillin is almost identical with the old unit derived from bioassay procedures.

The Antibiotic Spectrum and Principles of Penicillin Therapy. Penicillin is effective against the following types of pathogenic organisms: (1) gram-positive cocci, (2) gram-positive bacilli, (3) gram-negative diplococci, (4) spirochetes.

In order for penicillin therapy to be efficacious, the etiologic agent must be sensitive to this antibiotic in therapeutically attainable blood or tissue levels. The organism must be reached by effective concentrations of penicillin. Walled off processes such as an abscess, bone marrow, joints and bursae, necrotic tissue and eye infections cannot be treated effectively, in most instances, by the systemic administration of penicillin.

Organism susceptibility should be determined in critically ill patients, especially where there is some question as regards sensitivity. This should not delay therapy since such information can be obtained from simple swab technics and by blood cultures (blood sample drawn under sterile conditions just prior to initial therapy). The therapy should be continued sufficiently long to eliminate or greatly suppress the organism. Sensitivity tests serve only as a rough guide to desirable or necessary blood levels. Blood levels from two to 20 times that indicated by the approximate sensitivity tests may be necessary to eradicate the organism completely. In the final analysis, the response of the patient to treatment is the best guide to therapy as regards blood levels of any given antibiotic. Penicillin is highly effective and probably the antibiotic of choice in treating infections caused by the following organisms:

1. Gram-positive bacteria
   - Hemolytic streptococci—all groups
   - Streptococcus viridans
   - Streptococcus fecalis
   - Staphylococci (susceptible strains)
   - Pneumococci
   - B. anthracis
   - Clostridia
   - C. diphtheriae
2. Gram-negative bacteria
   - Bonococcus
3. Spirochetes
   - Syphilis, yaws
   - Spirilium minus

A variety of other bacteria are susceptible to the antibiotic effects of penicillin but probably much less so than to some of the newer antibacterial agents, such as aureomycin, terramycin and chloramphenicol, to be discussed later.

Bacterial Resistance to Penicillin. Bacteria which are ordinarily sensitive to penicillin may become resistant when subjected to subtherapeutic doses. Presumably a few organisms of a given strain survive, adapt themselves by mutation to the antibiotic and proliferate in its presence. New families of resistant strains may thus develop and retain their fastness even with repeated transfers. These organisms may ultimately replace the susceptible strains. Some bacteria are normally resistant to penicillin, such as E. coli, and have been shown to elaborate a substance, penicillinase, which rapidly inactivates penicillin.

The development of bacterial fastness to any antibiotic can be minimized or prevented by: (1) adequate initial therapy; (2) prolongation of the antibiotic therapy sufficiently to eradicate the pathogen completely; (3) avoiding the local and indiscriminate use of the antibiotics, especially in subclinical doses; (4) determination of the sensitivity index of a given organism and then administering many times the inhibitory dose.

Untoward Effects From Penicillin. In terms of therapeutic index, penicillin is probably the safest drug known. However, the incidence of untoward effects of this antibiotic, not directly related to its toxicity, has been estimated to range between 3 and 10 per cent. Some of the responses are relatively mild while others are of sufficient magnitude to contraindicate this drug. Among the commoner side effects are the following:

1. Penicillin rash—an allergic manifestation, sometimes urticarial in nature, generalized and associated with marked pruritis. In some cases this response may be controlled with antihistamines.

2. Dermatophytid reaction — noted in some patients with fungus infections of the skin. The local symptoms become exaggerated and there may be scaling of the hands and feet.

3. Thrombophlebitis following prolonged and continuous intravenous therapy as with the potassium salt of penicillin G, formerly employed in the treatment of subacute bacterial endocarditis.

4. Central nervous system irritation when administered intrathecally or intracisternally in concentrations of 1000 units per ml. or greater, or in a total dose exceeding 30,000 units.

5. The Jarisch-Herxheimer reaction may be seen in neurovascular and cardiovascular syphilis when full spirocheticidal doses of penicillin are administered in initial therapy. This is thought to be due to a massive destruction of the spirochetes with the liberation of "foreign proteins," producing a type of anaphylactoid response. The reaction may be avoided by the use of small doses of penicillin during initial therapy or by first attenuating the organisms with a less potent spirocheticide such as bismuth.

6. Fungus overgrowth. Oral reactions to the antibiotics have been observed with increasing frequency since the advent of inhalation and lozenge therapy with these agents. In the case of penicillin the changes in the oral cavity are described as glossitis, angular cheilosis and "black hairy tongue." These effects are due to changes in the oral flora, resulting in a predominance of Monilia albicans.

7. Angioneurotic edema, arthritis, erythema multiforme, chills and fever have been infrequently noted as untoward responses to penicillin therapy.

Sensitivity to pure penicillin or to the mold from which it is derived may occur.

Dosage. The dose of penicillin should vary with the nature and sensitivity of the infectious agent, route of administration and form of preparation. The average dose of the repository types of penicillin, such as procaine penicillin, for the usual infections is from 300,000 to 600,000 units intramuscularly one or twice daily. If oral medication with penicillin is preferred, the amount should be increased by three to five times and the interval shortened to three or four times daily one-half hour before meals or at least two hours after meals. In subacute bacterial endocarditis the dose of penicillin may be as high as 9,000,000 units per day, or more. With initial therapy in acute infections, crystalline penicillin, 100,000 units intramuscularly, is sufficient to establish a therapeutic level almost immediately. This level is then maintained by the longer acting forms.

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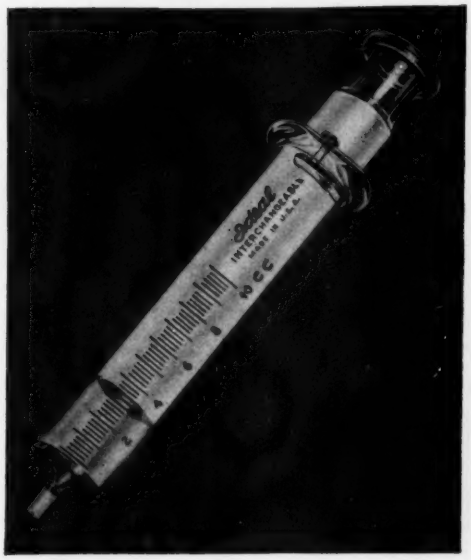

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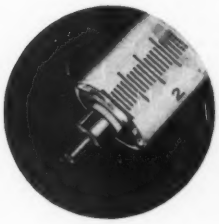

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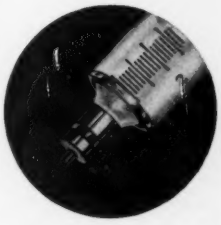

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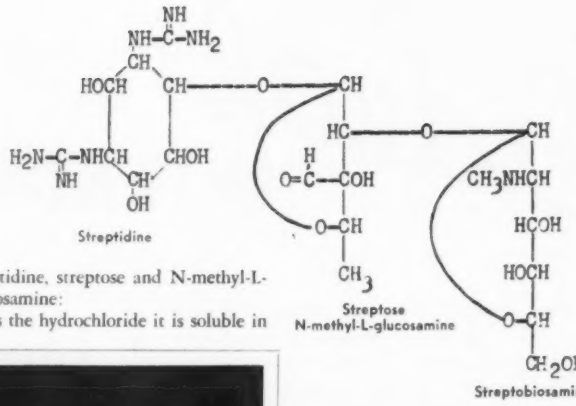
strains of Streptomyces griseus, soil microorganisms related to bacteria and fungi. Its antibacterial properties were first recognized by Waksman *et al.* in 1943. This agent stimulated widespread interest since it exhibited a selective activity against gram-negative bacteria, in contrast to penicillin which is chiefly effective against gram-positive organisms. In addition to this property streptomycin also has a marked effect against acid-fast bacilli.

Chemistry. Streptomycin is a complex molecule which on hydrolysis gives rise to three distinct substances: streptidine, streptose and N-methyl-L-glucosamine:



As the hydrochloride it is soluble in water but insoluble in organic solvents. It is easily converted into the sulfate, the trihydrochloride and the calcium chloride double salt. The free functional carbonyl group of the streptose moiety can be reduced catalytically to form dihydrostreptomycin, the antibacterial activity of which is almost comparable to that of streptomycin. Commercially available streptomycin salts (containing not more than 3 per cent moisture) are quite stable at room temperature. The Food and Drug Administration no longer requires that these preparations be refrigerated. Solutions, however, are much less stable and should be kept under refrigeration.

Pharmacology. Following intramuscular injection, streptomycin rapidly enters the circulation and diffuses into the tissues. Almost negligible amounts gain access to the cerebro-spinal fluid from this route of administration. It is hardly absorbed at all by the oral route but exercises a sterilizing effect in the intestinal tract. From 20 to 35 per cent of the parenterally administered streptomycin appears in the urine within a period of two hours, and from 50 to 70 per cent within 12 hours. In subjects with renal insufficiency the drug is retained in the body for longer periods of time, producing an accumulative effect when administered at the usual intervals of every six to eight hours. Serious toxic effects may result in such cases.

The pharmacodynamics of streptomycin is confused by virtue of the fact that original lots produced effects which were later shown to be due to the presence of impurities. In contrast to penicillin, however, this antibiotic, even in pure form, exhibits some definite acute effects when administered

intravenously, in doses far in excess of those needed to produce a chemotherapeutic effect in dogs and in monkeys. The intravenous LD_{50} dose is 200 mgm./kg. for mice, and 150 mgm./kg. for cats. Doses up to 100 mgm./kg./day in rats subcutaneously are well tolerated for several weeks. According to most workers in this field the following responses in the usual laboratory animals are fairly constant and are thought to be due to streptomycin as such:

1. Circulatory system. A gradual fall in blood pressure with intravenous doses of 200-400 mgm./kg. owing to paralysis of the vasomotor center. No direct cardiac effects have been observed as shown by the electrocardiogram.

2. Respiratory system. Small doses of streptomycin intravenously (in the order of 0.1 to 0.2 mgm./kg.) increase both the frequency and amplitude of respiration while doses 10 to 100 times as large cause respiratory depression. Respiratory depression is thought to be one of the first signs of acute poisoning from this antibiotic.

3. Hepatotoxic effects originally observed have been shown to be due to impurities. Pure streptomycin is devoid of hepatotoxic and renotoxic effects.

4. Neurotoxic effects. These will be discussed later in connection with the chronic administration of streptomycin and dihydrostreptomycin.

On the basis of its acute toxic effects in relation to its marked antibacterial activity, streptomycin is considered to possess a very wide margin of safety. However, certain untoward effects (to be discussed later) may be observed when this antibiotic is administered in therapeutic doses over long periods of time.

Standardization. The original method for the bioassay of streptomycin was based upon the inhibitory action of a given amount on a susceptible strain of bacteria. One unit is now defined as 1 microgram. Therefore one gram of pure streptomycin represents the activity of 1,000,000 units. The dose, however, is now established and spoken of usually in terms of weight rather than units.

Spectrum and Principles of Therapy With Streptomycin and Dihydrostreptomycin. Streptomycin differs from penicillin in several important repects. It is chiefly effective against gram-negative organisms, while penicillin is chiefly effective against gram-positive organisms. Streptomycin acts as a bacteriostatic agent in low concentrations and as a bactericidal agent in high concentrations, while penicillin is usually bacteriostatic in the usual therapeutic blood levels. The exact mechanism of action of streptomycin is not understood but it is thought to involve a combination of its guanido groups with nucleic acid or with sulfhydrol groups essential for bacteria which are sensitive to this antibiotic. The effective blood level has been estimated to range between 6 and 10 micrograms per ml. of serum. Satisfactory chemotherapeutic levels are obtained from dose intervals of six to eight hours, and hence no efforts have been expended on repository forms since the drug is slowly eliminated from the body.

In order that this antibiotic be efficacious in therapy the invading pathogen must be adequately sensitive within the range of serum levels attainable by parenteral administration. The oral administration of streptomycin is occasionally employed for "sterilization" of the intestinal tract as a preoperative measure in abdominal surgery, but this route of administration is totally inadequate for treating systemic infections since it is hardly absorbed at all by the oral route.

In acute infections, organism sensitivity should be estimated in a manner similar to that described for penicillin. The therapy should be of sufficient intensity and duration to suppress greatly or completely eradicate the organism. When in doubt as to the nature of the pathogen or when it is impractical to isolate the bacteria, combined therapy of both penicillin and streptomycin may be indicated.

Streptomycin or its reduced form, dihydrostreptomycin, is thought to be a drug of choice in treating infections caused by: (1) P. pestis (when combined with sulfadiazine), (2) P. tularensis, (3) K. pneumoniae (Friedlander), (4) Ducrey's bacillus, (5) M. tuberculosis when combined with daily dosage of p-aminosalicylic acid. (PAS not only has a synergistic action with streptomycin against the tubercle bacillus but it also retards the development of resistant strains.)

Streptomycin and dihydrostreptomycin are quite effective against a variety of other bacteria but newer antibiotics are preferable for many of these and hence the list of infections indicating the use of streptomycin has

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gradually shrunk. While at present streptomycin is the drug of choice in the treatment of certain types of tuberculosis, new chemotherapeutic agents such as derivatives of isonicotinic acid may ultimately replace this antibiotic.

Bacterial Resistance. Of all the antibiotics commonly in use today streptomycin is most noted for the rapidity with which resistant strains of bacteria emerge. Certain bacteria have been rendered streptomycin-dependent, requiring the presence of this agent for their optimal growth. Colon bacilli can become resistant to one thousand times the original lethal concentration within one week. M. tuberculosis, a relatively slowly developing organism, requires about three months to manifest resistance to streptomycin. This can be greatly retarded by the combined use of p-aminosalicylic acid (12 grams per day by mouth in divided doses) and streptomycin or dihydrostreptomycin in the treatment of tuberculosis.

Because of the propensity of this antibiotic to render certain organisms fast to its antibacterial effects full therapeutic doses should be employed in any situation in which it is indicated. Organism sensitivity should be determined not only prior to initial therapy, where feasible, but periodically throughout the course of therapy. The dose should be adjusted to produce a serum level two to four times that to which the organism is sensitive, for once fastness develops, greatly increased doses may fail to control the infection. In the case of tuberculosis the best results have been obtained in miliary tuberculosis, tuberculosis of the larynx, trachea, bronchi and in tuberculous meningitis.

Untoward Effects. Serious toxic effects to date are commoner with streptomycin therapy than with penicillin or any other commonly used antibiotic. The most important of these are:

1. Neurotoxic action—manifested by disturbances in vestibular and auditory functions which may be irreversible. This type of response is most likely to occur in the chronic use of the drug as in the treatment of tuberculosis. Dihydrostreptomycin is thought to be less toxic in this regard and probably should be substituted for streptomycin when prolonged therapy is contemplated. To forestall serious eighth nerve damage, patients on chronic therapy with either streptomycin or dihydrostreptomycin should have periodic hearing tests and tests for disturbances in vestibular function (caloric or syringe test).

2. Vascular reactions — generalized vascular reactions resembling the effects of histamine have been noted. These are a fall in blood pressure, generalized flush over the face and upper chest, and occasionally nausea and vomiting. These reactions are relatively rare and many observers have attributed them to impurities.

3. Allergic reactions are less common than with penicillin. These are skin rashes accompanied by eosinophilia, fever and arthralgia.

4. Tonic and clonic convulsions have been observed, though rarely, when streptomycin or dihydrostreptomycin was administered intracisternally in the treatment of tuberculous meningitis.

Dosage and Dosage Forms. The dose range of streptomycin or dihydrostreptomycin varies between 0.5 and 1.0 gram two to three times daily, administered intramuscularly. For intrathecal use the concentration should not exceed 15 mgm./cc., administered slowly to prevent the occurrence of the nitritoid crisis seen with higher concentrations. Inhalation therapy has been employed in the form of a mist for the treatment of tuberculosis of the larynx, lung abscesses and chronic pulmonary infections involving susceptible organisms. A daily dose of 0.5 gram when administered with a suitable nebulizer at varying intervals during a 24 hour period has produced good results. For urinary tract infections streptomycin is thought to give better results if the urine is alkaline. Sodium bicarbonate or sodium citrate in a dose of 1 gram every six hours is usually sufficient to alkalinize the urine. In the treatment of tuberculosis, p-aminosalicylic acid, 6 to 12 grams daily in divided doses, is employed almost routinely (for reasons given) and is usually well tolerated.

Streptomycin is available as the trihydrochloride and as the sulfate. Dihydrostreptomycin is available as the sulfate salt. The calcium chloride complex is also available but is less frequently employed. Any of the salts may be administered in capsule form for the purpose of treating intestinal infections or for sterilizing the intestinal tract as a preoperative measure in abdominal surgery such as an intestinal resection. — THEODORE R. SHERROD, PH.D., M.D.

Food Service in Small Hospitals

3. PREPARING AND SERVING POULTRY, FISH, DAIRY PRODUCTS

ROSALIND C. LIFQUIST
Food Economist
Bureau of Human Nutrition
and Home Economics
U.S. Department of Agriculture

JANE HARTMAN
Food Service Director
Maryland State Department of Health
Baltimore

Poultry.—Chicken and turkeys have been so improved that they are literally new birds. Now plentiful the year around, chickens or turkeys can be served any day instead of as a holiday treat.

Purchasing. Poultry may be bought live, dressed or ready-to-cook. A dressed bird is one that has been bled and picked but not drawn; head and feet have not been removed. Those labeled ready-to-cook are fully drawn (eviscerated), and thoroughly cleaned inside and out, and pinfeathers are removed.

FIGURE ON LABOR COST

It may not be an economy to buy live or dressed birds, especially if preparation time is considered. Of course, dressed birds cost more per pound than live ones, and ready-to-cook birds cost more per pound than dressed. But the dollar spent on live and dressed birds pays for more waste. Therefore, the actual cost per pound of ready-to-cook weight may be about the same, regardless of how the poultry is purchased. Watch prices and yield, taking into account labor costs in your institution.

For top quality poultry, look for the plump bird with well-fleshed breast and legs, well-distributed fat, and skin that has few, if any, blemishes and pinfeathers.

Some poultry is federally inspected for wholesomeness, some is graded for quality, and some is both graded and inspected.

This, the third of a series of articles designed to assist dietary department supervisors and administrators in small institutions with the operation of a food service, deals chiefly with food preparation and serving.

If poultry is to be cooked within a day or two after purchasing it should be stored at low temperature (35° to 40° F.). Otherwise, poultry should be frozen at 0° F. or lower. Thawing a frozen bird the day before it is to be prepared saves cooking time.

Thaw in a cold room, or in the refrigerator, allowing air to circulate around each bird. Draw as soon as thawed. A 20 pound turkey will take about two days to thaw. Thawing at room temperature is not advisable for large birds.

Turkeys now come both smaller and larger, and hence are adaptable to many uses: divided and prepared as "turkey parts"—halves, quarters, legs, breasts, or roasted whole for slicing. For institutional use, the large heavyweight turkeys, for instance the "Broad Breasted Bronze," are an excellent choice. Toms of this type average 17 to 24 pounds ready-to-cook weight; hens, 10 to 14 pounds. The toms may weigh as much as 28 to 30 pounds ready-to-cook.

Cooking. To roast a whole turkey evenly, start it on one side of the breast, turn to the other side, and then to the back. Turn about every 1½ hours, basting with drippings every time the bird is turned. It is done when the joints can be moved easily.

Choose plump young chickens for broiling, frying or roasting. The smaller sizes are best for broiling. Young birds have smooth, tender skin; soft, tender meat, and a flexible breastbone. Older birds, suitable for stewing or braising, have less tender meat, coarser skin, and a firm breastbone.

Fish.—Fish, whether fresh, frozen or canned, is a good protein food and should be used frequently, especially where it is less expensive than meat.

Purchasing. The most important points in buying fish are to buy only the amount needed for immediate use unless freezing facilities are available, and to be certain the fish is fresh.

Cooking. Fish is easy to cook, requiring a relatively short time and low temperature. Remember there are other methods than frying for cooking fish.

Eggs.—*Cooking.* Eggs are difficult to prepare in institutions chiefly because they usually must be served *hot* to be enjoyed. If there are several points of service, cooking equipment is needed at each place so that eggs can be served as cooked.

A grill is best for fried eggs. Cook directly on the grill, being careful that it doesn't get too hot. If eggs are cooked individually as served, a rounded lid over the egg will "self-baste" the top.

Use an automatic timer for soft or hard-cooked eggs. Otherwise, timing must be carefully watched. Unless they are started in cold water, eggs should be kept at room temperature for a short time before cooking so that the shells will be less likely to crack and cooking will be more nearly uniform. Keep water simmering (just below boiling). If allowed to boil, eggs will be tough.

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Dried eggs, increasingly popular for cooking, should be reconstituted before they are used. To do this, use equal measures of the egg powder and either cold water or cold milk. Measure the powder into a mixing bowl, add about one-third of the liquid and mix with a spoon until smooth. Continue adding liquid while stirring. As lumps form, work them out with a spoon against the side of the bowl.

For larger amounts, a pound or more, measure the powder into a bowl, add one-half of the liquid and push the powder down under the liquid. Let stand for 5 minutes so that the powder will absorb water. Beat with a whip or beater until smooth, adding remainder of the liquid. Two tablespoons of firmly packed dried egg powder mixed with 2½ tablespoons of water equal one egg; ¾ cup dried egg powder mixed with 1 cup (less 1 tablespoon) water equal 6 eggs.

Use dried eggs *only* in dishes that are to be thoroughly cooked.

Coffee.—Coffee is so important to most adults that its preparation is worth considerable effort and attention. The best method is to prepare coffee with freshly boiled water just before serving time. Then keep at a constant temperature and *never* repeat. Manufacturers' directions for use of equipment should be followed carefully.

Table 1.—Approximate Scoop or Dipper Equivalents

Dipper Number	*Approximate Equivalent Measure*	*Suggested Use*
30	2 Tablespoons +	Drop cookies
20	3 Tablespoons +	Muffins, cupcakes, sauces
16	4 Tablespoons (¼ cup)	Muffins, desserts, croquettes
12	5 Tablespoons + (⅓ cup)	Croquettes, vegetables, muffins, desserts, salads
10	6 Tablespoons +	Desserts, meat patties, vegetables, hot cereals
8	8 Tablespoons (½ cup)	Luncheon dishes, creamed meats
6	10 Tablespoons + (⅔ cup)	Luncheon salads

KEEP EQUIPMENT CLEAN

Equipment should be kept scrupulously clean. If not, oil left from the previous brew will become rancid and impart an off-flavor to the following brew. After each meal, the urn should be thoroughly washed, rinsed and allowed to air; the coffee bag should be emptied, washed in clear water, and allowed to dry in a well ventilated place. Use a fresh coffee bag daily when large quantities of coffee are brewed. When a good technic has been developed, stick to it.

The reader may feel at this point that we favor, to an impractical degree, the "last minute" preparation of food. It cannot be denied that cooking during serving is best for many foods and that often employes rebel at this. There are supervisors, as well as cooks, who consider it best management to have every dish ready to go at serving time and the kitchen in apple pie order. In the interest of those served, serving time should be the kitchen employes' peak work period—not their rest period. Their adjustment to this point of view may take time and may entail some revision of work schedules. However, this is sufficiently important to warrant more consideration than it often receives.

On the other hand, many foods such as cereals, certain desserts, some salad fillings, fruit, especially dried fruit, some casserole dishes, and many roasts (which slice better upon standing) can be prepared ahead of time or can be cooking during the service period without too much watching. Taking these factors into consideration when menus are being planned will eliminate having too many "last minute" foods.

Milk.—*Cooking.* Milk cookery as such may not be an individual problem since this food is generally combined with other food. However, a discussion of the use of two economical forms of milk, evaporated and nonfat dry milk, is included here.

When institutions must operate on a low-cost budget, the use of fluid whole milk is often restricted. Substantial savings can be made by using evaporated milk and nonfat dry milk, both of which are satisfactory forms of milk for many purposes.

Evaporated milk (whole milk with about half the water removed) can be diluted with equal quantities of water and used in the same manner as whole milk in puddings, cooked cereals, creamed soups, vegetable dishes, sauces, custards and baked goods. Some people enjoy it as a beverage; undiluted it can be used in place of cream in coffee.

Nonfat dry milk is inexpensive, easy to use, and easy to store. Its flavor has been so improved in the last few years that in addition to its many uses in cooking, it is well liked as a beverage. Reconstituted, it can replace fluid or evaporated milk in the dishes mentioned or it can be used in some baked goods without being reconstituted.

For 1 quart of reconstituted milk, use 1 cup or 4 ounces of nonfat dry milk and 4 cups of warm water (or follow the manufacturers' proportions). Sprinkle dry milk on top of warm water and beat well with rotary beater, whip or power mixer. This method helps keep the dry milk from lumping and sticking to the bowl. Never add dry milk to boiling water.

When recipes contain a large proportion of dry ingredients, for example, bread, biscuits, muffins and cake, dry milk may be mixed with the other dry ingredients.

ATTRACTIVE SERVICE

Portioning food is most important because it affects the attractiveness of the plates served, as well as food costs.

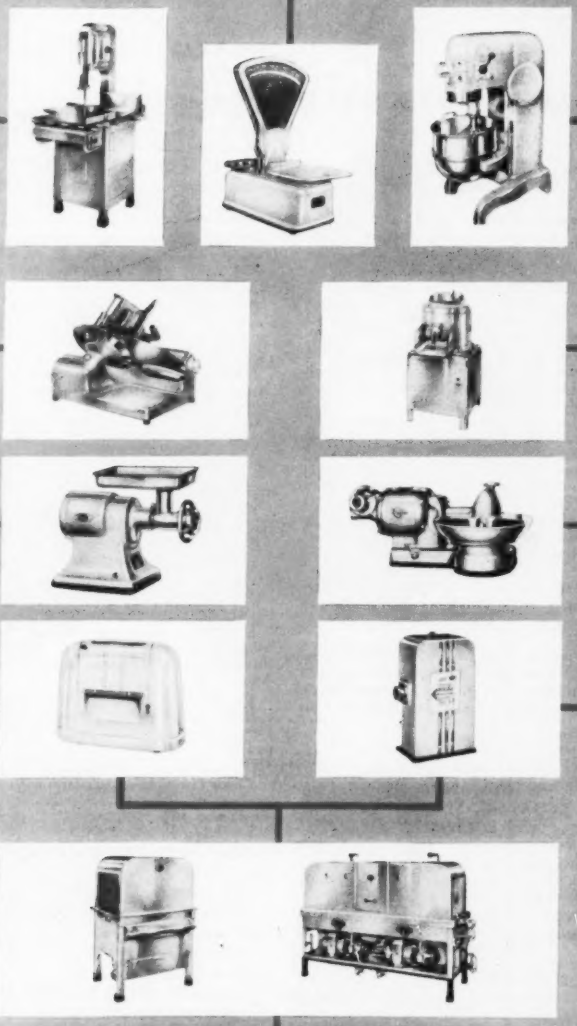
The portion size should be the one best suited to the needs and preferences of the group. If portion size is too large, it may dull the appetite and result in waste. Once a portion size is determined, adhere to it and estimate servings from recipes that call for this portion size.

Portion control and cost control are inseparable inasmuch as quantities of food to be purchased are most efficiently determined by portion yields of recipes. When portion control is not observed, purchase estimates will be largely hit or miss, resulting either in a shortage of supplies or waste and increased cost of food.

Whenever possible, portion food in the kitchen by using individual dishes for desserts, cutting cakes and pies

Clean Plate to Clean Plate

Hobart Charts the Way to Peak Kitchen Efficiency



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routinely into a predetermined number of pieces, and preparing meat in individual servings. Standard scoops are useful for portioning soft foods, such as mashed potatoes, dressing and ice cream. Table 1 gives the approximate size scoops to use for average servings of various types of food.

Attractive food service and control of food temperatures in a cafeteria are not too difficult to achieve. The counter can be arranged invitingly. Proper equipment will keep food at correct serving temperatures. Freshly cooked supplies of those foods that deteriorate rapidly on standing will assure good flavor.

In institutions where the food service is distant from the kitchen, it may be difficult to keep food in good condition. When this situation exists, all factors adversely affecting the food quality during transit and serving should be studied and changes should be made to correct weak points. If the use of heated conveyors from the kitchen to service is not possible, other measures can be tried. For example, insist that food be put into hot containers and then speed the trip to the point of service, avoiding drafts, cold halls, and elevators whenever possible. Serve food *immediately* on heated plates.

The next article in this series concerns nutritional and food cost accounting.

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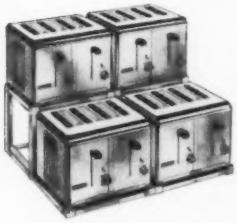

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FOOD FOR THOUGHT

Color of Tomato Juice

The color of tomato juice can be accurately and rapidly measured by a photoelectric instrument, food scientists of the New York State Experiment Station, Geneva, N. Y., report. They add that under uniform processing conditions, the color of canned tomato juice may be predicted from the color of the raw tomatoes. This makes it possible to standardize the color of the juice by controlling the trimming and by blending the raw materials.

These findings have a direct practical application to both the grower and the processor because of the great importance placed on color in determining the grade standards of both raw tomatoes and tomato juice.

In well operated tomato juice canning plants, poor color is the cause for down-grading in the majority of cases, say the food scientists. The importance of color emphasizes the need for accurate, speedy methods for measuring color. The loss in financial return resulting from down-grading because of poor color is especially hard because tomato juice with a low grade may cost as much to produce as that with a top grade. Photoelectric instruments for measuring color thus may be important in saving expense.

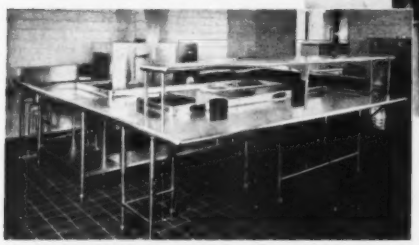
ideas

from Blickman-Built award-winning food service installations

tray production unit provides assembly-line efficiency

AT GREENWICH HOSPITAL, GREENWICH, CONN.

TRAY PRODUCTION UNIT in main kitchen, adjacent to cooking center. Trays move on long conveyor belt between two counters. Attendants load trays from both sides according to a card control which indicates special diets or patients' preferences. Note convenient placement of steam table, coffee urns, toaster, etc. Built-in "Lowerators" dispense trays and dishes at counter level. Loaded trays are placed in insulated tray trucks for distribution to patients.



MAIN DISH PANTRY, showing dish washer at left, glass washer at right. Long shelf in foreground holds trays during unloading process. Pass window at right opens directly to tray production area. Stainless steel dish tables are fully welded throughout. Round corners and seamless, crevice-free tops facilitate cleaning, assure hospital-standard sanitation.

SALAD AND VEGETABLE PREPARATION UNIT — View shows convenient position of work tables in relation to sinks. Note how ample spacing between units permits freedom of movement for personnel. These layout factors help speed procedures. Wall-mounting of stainless steel sinks in background eliminates leg obstructions, permits thorough cleaning of floor surfaces.

• By applying assembly-line methods to the distribution of food to patients, Greenwich Hospital has achieved substantial savings in time and labor. A mechanical tray-loading unit, located in the main kitchen, is the key to an efficient central service system. Trays, moving along a conveyor belt, are loaded by attendants from both sides. All equipment is conveniently placed to speed the operation. Insulated conveyors are used to distribute the loaded trays to the various floors. Food reaches the patients on time, kitchen-fresh and palatable.

The complete food service installation at Greenwich Hospital handles the preparation and distribution of approximately 1275 meals daily to patients and employees. Efficient work flow is achieved through carefully-planned arrangement and functional design of equipment. Seamless, stainless steel construction of individual units assures a high degree of sanitation and low maintenance costs.

This installation, planned and equipped by S. Blickman, Inc., received an Honor Award in the 1952 Institutions Food Service Contest. You, too, can have food service equipment that rates high in every respect—efficiency, appearance, durability, sanitation—by specifying "Blickman-Built."

***Send for illustrated folder** describing Blickman-Built Food Service Equipment — available in single units or complete installations.*

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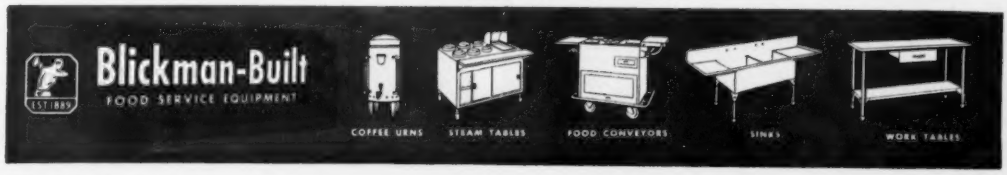


Menus for November 1952

Esther Loder
Dietitian
Bryan Memorial Hospital
Lincoln, Neb.

1 Stewed Raisins Crisp Bacon, Muffins • New England Dinner: Potato-Carrots-Cabbage-Onions Spiced Apple Salad Creamed Tapioca • Split Pea Soup Cheese Fondue Stewed Tomatoes Fruit Cup Brownies	**2** Orange Halves Scrambled Eggs • Roast Beef, Gravy Browned Potatoes Buttered Peas Relishes, Carrot Curls Celery Sticks Apricot Dessert • Vegetable Soup Creamed Chicken Steamed Rice Asparagus Frozen Fruit Salad	**3** Grapefruit Poached Egg • Pork Chop Mashed Potatoes Baked Squash Head Lettuce Salad Baked Apple • Baked Potato Creamed Chipped Beef Chef's Salad Caramel Custard	**4** Applesauce Pancakes and Sirup • Broiled Liver Escalloped Potatoes Acorn Squash Relishes Coconut Cream Pie • Chili con Carne Wholewheat Muffins Green Salad Apricot Upside-Down Cake	**5** Fruit Compote Bacon, Muffins • Pot Roast, Gravy Steamed Potato Green Lima Beans Coleslaw With Caraway Seed Pineapple Fluff • Tomato Soup Chicken Fricassee, Steamed Rice Buttered Green Beans Olives, Celery Sticks Pineapple Sherbet Wafers	**6** Orange Juice Soft Cooked Eggs • Roast Beef Browned Potato, Gravy Whole Kernel Corn Beet Salad Butterscotch Pudding • Escalloped Tuna Stewed Tomatoes Celery Hearts Chef's Salad Lemon Pie
7 Stewed Apricots Scrambled Eggs • Baked Salmon Creamed Potatoes Escalloped Egg Plant Head Lettuce With French Dressing Lemon Whip • Macaroni and Cheese Buttered Asparagus Tomato and Egg Salad Peaches Sugar Cookies	**8** Kadota Figs Sausage, Muffins • Irish Stew With Vegetables Baking Powder Biscuit Orange, Cress Salad Apple Pan Dowdy • Hot Steak Sandwiches Head Lettuce Salad Grilled Tomato Chocolate Sundae	**9** Grape Juice Poached Eggs, Toast • Baked Chicken and Dressing Whipped Potatoes, Gravy Mixed Vegetables Spiced Grape Salad Hot Rolls Ice Cream • Potato Salad Cold Sliced Tongue Deviled Eggs Fruit Cocktail Angel Food Cake	**10** Stewed Prunes Crisp Bacon, Toast • Meat Loaf Escalloped Potatoes Fried Egg Plant Frozen Fruit Salad Coconut Frosted Cake • Oyster Stew Egg Sandwiches Pickles Pear Salad Brownies	**11** Sliced Oranges Fried Eggs, Toast • Pot Roast, Gravy Mashed Potatoes Buttered Yellow Turnips Apple and Raisin Salad Vanilla Blanc Mange • Clear Tomato Soup Tuna, Celery, Pea Salad Hot Butterflake Rolls Currant Jelly Fruit Tapioca	**12** Fruit Compote Bacon Popovers • Barbecued Meat Balls French Fried Potatoes Buttered Spinach Shredded Carrots With Lemon Dressing Cream Pie • Tomato Juice Ham and Macaroni Roll Mixed Green Salad Blue Plums Lady Fingers
13 Blended Juice Scrambled Eggs • Stuffed Breast of Veal Mashed Potatoes Parslied Carrots Molded Vegetable Salad Cherry Sponge Cake • Creamed Pea Soup Baked Acorn Squash Link Sausages Vegetable Relishes Baked Apple	**14** Grape Juice French Toast, Sirup • Baked Catfish Parsley Creamed Potatoes Stewed Tomatoes Head Lettuce With 1000 Island Dressing Lemon Cake • Frankfurter Vegetable Dinner With Hot Biscuits Tomato Preserves Green Salad Fruit Cup	**15** Stewed Raisins Boiled Egg, Toast • Beef Pot Roast With Potato Pancakes Mashed Rutabaga Mixed Vegetable Salad Cherry Tapioca • Tomato Soup Escalloped Tuna With Noodles Buttered Green Beans Carrot Sticks Fruit Gelatin	**16** Orange Halves Toast • Stewed Chicken, Noodles Cauliflower With Buttered Crumbs Stuffed Celery Sticks Hot Rolls, Jelly Strawberry Ice Cream • Potato Salad Asparagus Wrapped in Ham Radishes Hot Rolls, Jam Pears, Wafers	**17** Applesauce Bacon, Muffins • Swiss Steak Mashed Potatoes, Gravy Buttered Carrots, Peas Coleslaw Angel Food Cake • Cheese, Bacon and Tomato Rabbit on Toast Asparagus, Egg Salad Blueberry Pie	**18** Sliced Banana Toast • Meat Pie With Vegetables Flaky Pastry Topping Tossed Salad Butterscotch Blanc Mange • Canadian Bacon Corn Fritters, Sirup Lettuce Wedge With French Dressing Apple Pan Dowdy
19 Pineapple Juice Pancakes, Sirup • Barbecued Meat Balls Baked Potato Buttered Asparagus Perfection Salad Cherry Cobbler • Oysters Escalloped With Corn Vegetable Relishes Fruit Salad Oatmeal Cookies	**20** Rhubarb Eggs, Toast • Lamb Pattie With Caper Sauce Buttered Lima Beans Broiled Half Tomato Cabbage Salad Bread Pudding de Luxe • Spiced Ham and Vegetable Omelet Wholewheat Muffins, Jam Tossed Salad Blushing Pears Wafers	**21** Grapefruit Bacon, Muffins • Tenderloin of Trout Tartare Sauce Escalloped Potatoes Spinach With Lemon Tomato Aspic Lemon Pie • Kidney Bean Salad Deviled Eggs Blueberry Muffins Jam Carrot Curls Celery Sticks Butterscotch Cake	**22** Grape Juice Poached Egg on Toast • Veal Chop Buttered Noodles Parslied Carrots Lettuce Salad With 1000 Island Dressing Prune Whip • Creamed Chipped Beef Baked Potato Buttered Spinach Peach Salad Chocolate Cookies	**23** Tangerines Rolls, Sausages • Baked Ham Candied Sweet Potatoes Creamed Peas Cinnamon Apple Salad Maple Charlotte • Hot Tomato Soup Combination Sandwiches Pickle Slices Crisp Potato Chips Spanish Fruit Cream	**24** Fruit Compote French Toast, Sirup • Broiled Liver and Bacon Hashed Browned Potatoes Spanish Corn Sunset Salad Rhubarb Sauce Cookies • Vegetable Rabbit With Sliced Tomato Buttered Whole Carrots Crisp Green Salad Butterscotch Brownies
25 Banana Fried Eggs • Stuffed Pork Chop Whipped Potatoes New Peas Cucumber Pickles Pineapple Chiffon Dessert • Chili, Cheese and Bun Hashed Brown Potatoes Fruit Salad Devil's Food Cake	**26** Oranges Pancake, Apricot Sirup • New England Dinner Piccalilli Bread Pudding de Luxe • Escalloped Potatoes and Wieners Buttered Beets Apple Tapioca Sugar Cookies	**27** Broiled Grapefruit Bacon, Rolls • Tomato Juice Cocktail Roast Turkey and Dressing Cranberry Sauce Mashed Potatoes Brussels Sprouts Olives, Carrots, Celery Pumpkin Pie • Oyster Stew, Crackers Egg Sandwiches Dill Pickles Fruit Salad Orange Cup Cake	**28** Stewed Prunes Toast, Jelly • Catfish Fillet With Tartare Sauce Buttered Crumb Potato Cold Tomato Coleslaw Washington Pie • Turkey With Mushroom Sauce Steamed Rice Buttered Green Beans Lettuce Wedge With French Dressing Apricot Upside-Down Cake	**29** Blended Fruit Juice Soft Cooked Egg • Rolled Roast of Lamb Tarragon Sauce Delmonico Potato Peas With Celery Grapefruit Salad Jelly Roll • French Onion Soup Chicken Salad Potato Flakes Tomato Wedge Chilled Fruit Cup Wafers	**30** Pineapple Tidbits Poached Egg, Toast • Meat Loaf Escalloped Potato Baked Squash Pineapple, Cabbage Salad Blueberry Pudding • Individual Chicken Pie Buttered Carrots Waldorf Salad Caramel Custard

Ready-to-eat or cooked cereals served on all breakfast menus.

A "new look" at Prunes nature's energizer

What's in a normal serving of Prunes?

A normal serving of prunes and juice is 75 grams (4 or 5 medium-size prunes with 2 tablespoons of juice) and contains approximately 86 calories, if cooked without sugar. If cooked with sugar (½ cup to 1 pound prunes), a serving contains 119 calories. The addition of lemon or lemon peel in cooking will vary these figures very slightly.

Approximate Composition* of a serving of prunes

	WITHOUT SUGAR	WITH SUGAR
Carbohydrates	22.7 grams	31.2 grams
Protein	.7 grams	.7 grams
Fat	.2 grams	.2 grams
Fiber	.6 grams	.6 grams

Vitamins* in a serving of prunes

A	545 International Units
Thiamine (B_1)	22 micrograms
Riboflavin (B_2)	45 micrograms
Niacin	.4 milligrams
C and D	Traces only

Minerals* in a serving of prunes

Iron	1.3 milligrams
Phosphorous	27 milligrams
Calcium	17 milligrams
Sodium	4 milligrams
Potassium	400 milligrams
Copper	.13 milligrams

*(Tables based on "Food Value of Portions Commonly Used," Bowes and Church, 7th Edition, 1951)

Those who plan meals for large groups find that prunes are consistently one of the better-liked fruits possessing high nutritional qualities. Furthermore, prunes are universally recognized as excellent regulators of the large intestine, and one of nature's best mild laxatives. Check these plus values of prunes. You'll find prunes a superlative fruit to serve often!

the California wonder **Prunes** fruit!

California Prune Marketing Program

The Right Communication System

can ease the nurse shortage

A. A. LEPINOT
Assistant Administrator
St. Luke's Hospital, Cleveland

PART I

WHAT can be done about the acute shortage of nursing personnel?

An approach which was used at St. Luke's Hospital, Cleveland, to ease this problem was to install a more highly developed and efficient system of communication between the patient and the nurse. Modern advancements in the field of electronics and the application of these principles to our specific hospital problems have resulted in a system which is far more efficient than the conventional types of hospital communication systems heretofore employed. At the same time, it has enabled the nursing staff to render better care to the patient. With the help of this new communication system, we have been able to operate the same facilities with reduced nursing staffs, resulting from the general nurse shortage.

This new medium is a two-way voice system. The patient voices his request by speaking in a normal tone from any position in bed, and he is answered immediately by voice from the nurses' station. In this way the request can be promptly fulfilled. The patient's signaling device is then automatically placed in position for a future call.

TEST PERIOD SUCCESSFUL

Following a test period on two nursing divisions, we decided to install the two-way voice system on all nursing divisions in the hospital. During our experience with the operation of this communication system, it has proved itself to be a considerable time and traffic saver to the nursing personnel. It has enabled the nurses to render more service to the patient much more promptly than ever before. The saving of steps and reduction of associated fatigue has enabled the nurse to spread her energy to more patients. It is possible to organize the nursing staff on the division more efficiently with the help of this type of communication system. It has a desirable effect on morale of the nursing personnel.

SYSTEM NOT COSTLY

This modern communication system is not costly. When all accommodations in the hospital are completely installed, the cost per bed is not high. The bulk of the labor to install the system can be supplied by the maintenance department under competent supervision, which greatly reduces the cost. The savings in salaries of nursing personnel will amortize the initial investment in a short time.

Many methods of patient-nurse communication have been used and are now being used in hospitals. All have advantages and disadvantages.

Communication systems making use of sound alone to make contact between the patient and the nurse are undesirable because the noise is irritating to those not concerned. The "holler" method, the hand bell, and the buzzer come under this category. There are some sound systems installed at present in which a soft toned chime is used. This chime is much less disturbing to patients and meets with few if any complaints. The chief objection to the straight sound system is that the nurse must travel to the patient's bedside in order to learn his needs. She must then return, perhaps to the nurses' station or some other room, to locate the object of the request, and return to the patient's bedside. The total travel involved—two round trips between the nurses' station and the patient's bedside.

Another disadvantage is that a nurse may answer the patient's buzzer or bell and, rather than look for a nurse's aide who could actually carry out the request, perform the duty herself. Thus, skilled nursing time is spent where it could have been saved and applied in caring for a more seriously ill patient or in a procedure which requires the skill of a nurse.

A type of nurse call system used widely in hospitals today is the light system with either the pull cord or the push button type of signaling device. The pull cord station consists of a tumbler or toggle switch mounted in the wall above the bed. This switch is operated by a pull cord.

The push-button signaling device consists of a pear shaped housing unit connected with a rubber insulated cord to a large plug which fits into a wall receptacle.

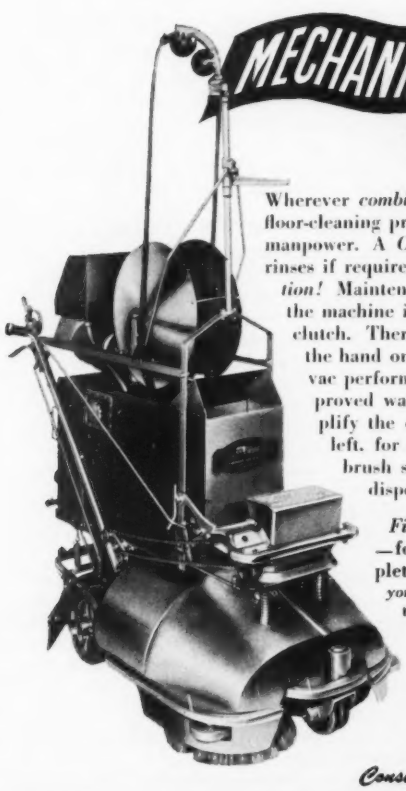
In order to initiate a call, the patient either pulls down on the cord or depresses the center of the locking push button located at his bedside. A circuit is then closed, lighting a numbered lamp at the nurses' station which tells the nurse the room from which the call originated. A lamp is lighted in the corridor directly over the entrance to the patient's room and lamps are also lighted in the utility rooms and diet kitchens in some of these systems. In the more elaborate light systems, a signal lamp is provided at each bed so that the nurse, upon entering a multiple bed ward, can immediately determine which patient placed the call. Some of these light systems also provide a signaling device in the patient's toilet and bath.

PROS AND CONS OF LIGHT SYSTEM

The main advantages of light communication systems are that they are quiet, simple, safe and inexpensive. An important disadvantage is that light signals are not always seen by the nurse and may go unanswered. In order to avoid this pitfall, some hospitals have stationed a person in the vicinity of the light panel with sufficient other clerical tasks assigned to her so as to form a complete job. The most significant disadvantage of any light system is the same as that of the straight sound systems—the nurse must travel to the patient's room in order to learn the nature of his request. A contingent disadvantage is that a nurse may answer a call which could have been answered and fulfilled by a nurse's aide. This wastes skilled nurse time.

In the light systems involving the pull cord signaling device, the nurse or person answering the call must turn the patient's switch to the up position (reset) while she is in the patient's

Let's not clean away dollars and man-hours with costly, inadequate floor care



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room. Occasionally, when the patient is well enough, he may reset his own switch so that it is ready for a later call; however, in most instances it is done by the nurse. This makes a trip to the patient's bedside mandatory for each call. A disadvantage to the toggle switch signaling device has been said to be that the noise of the switch may disturb another patient in the same or adjoining room. This noise, if prevalent, can be eliminated by the use of the mercury switch.

With the locking push-button signaling device, the patient can reset his own signal by depressing the outer rim area of the device, in which case the button returns to the off position and the lights are turned off. This patient-reset feature has gained wide acceptance.

COMBINATION LIGHTS AND BUZZER

There are also patient-nurse communication systems in use involving a combination of lights and buzzers. The buzzer can either be sounded intermittently by the patient when his call is not promptly answered, or it may be set to provide audible warning after a predetermined time, say five minutes, should the signal not have been answered.

The advantage of the combination system is that there is assurance that the patient's call will not go unnoticed. However, the buzzer signal, as mentioned previously, is disturbing. And it is true that some patients with a buzzer signal in their control can irritate many other patients and cause distress to the nursing staff. A chime would undoubtedly be a much better choice for systems of this type. The objection previously mentioned to any system using lights for initial contact is that some calls may not be answered promptly unless a person is stationed to watch the panel.

The chief disadvantage again is the requirement that the nurse must travel to the patient's room in order to learn the patient's request.

One of the earliest voice communication systems is the one-way system in which there is patient to nurse voice communication only. The feeling behind making only the one-way voice installation was that about 5 per cent of the patient calls required an immediate answer. We have found this percentage to be much higher and many steps have been saved with the two-way voice system.

In this one-way voice system, the microphone is mounted on a swinging arm at each patient's bedside and connected to a loud speaker installed in the nurses' station, utility room, and other places where the nurses might be employed. The patient requiring attention draws the microphone toward him, switches it on and states his name and his request. The switch lights a signal lamp in each room indicating to other patients that the system is in use and cannot be used by them until the signal light disappears.

A distinct advantage of the one-way voice system is that the patient can voice his request to the nurses' station and the proper person can be dispatched to fulfill the request. This alone saves many steps to the patient's bedside. One of the disadvantages in this system is that the patient does not receive a prompt acknowledgement of his call. He never has the assurance that his voice is actually being heard. The chief disadvantage is that for every call registered there must be at least one trip to the bedside. Many of the patient's requests are simply for information which could be answered from the nurses' station with a two-way voice system and thereby save a trip to the patient's room.

TWO-WAY VOICE SYSTEMS

There have been two-way voice communication systems in a few hospitals for some time, but it has been only recently that certain improvements have resulted in a really acceptable system.

There are some two-way patient-nurse communcation systems in which the patient operates a switch to talk and listen. The patient's request is transmitted to a loudspeaker installed in the nurses' station. There is also a buzzer which the patient can sound by moving his switch to the proper position.

This two-way system has many advantages. The patient can voice the nature of his request which will usually save at least one trip to the bedside. The nurse acknowledges his request through a microphone at the nurses' station which assures the patient promptly that his request will be fulfilled.

The disadvantage with this type of two-way voice system, however, has been that the nurse must still travel to the patient's bedside in order to reset the patient's signal. Those systems which now incorporate the automatic reset feature, suggested by Dr. Fred G.

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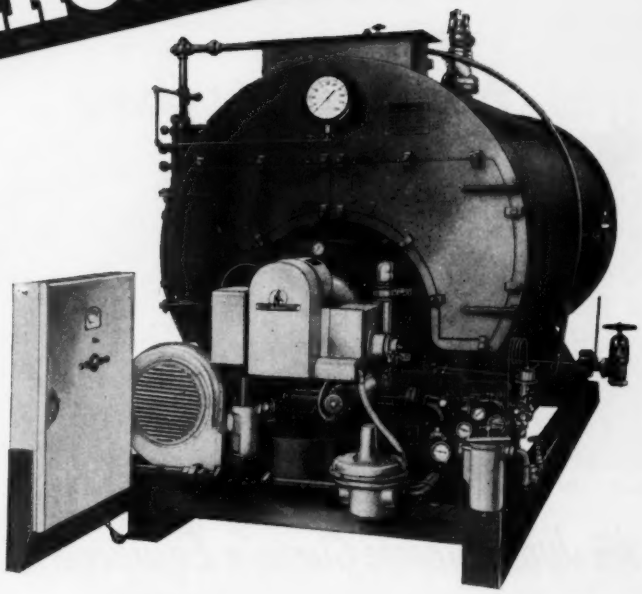

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The burner, including all controls, built-in forced draft fan and oil pre-heating system, is completely assembled, wired, tested and shipped to the installation site from Iron Fireman. The boiler, completely assembled with all of its essential elements, is shipped from Kewanee. Matching connections are provided for quick, easy installation.

Available for high pressure steam in sizes with outputs ranging from 52 to 456 h.p., 125 and 150 lb. working pressure, and also from 5470 EDR 15 lb. steam or 30 lb. water. These units may be automatically fired with No. 6 or lighter fuel oils, gas (either high pressure or as low as 2 oz.) or a combination of both fuels.

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Carter, superintendent of St. Luke's Hospital, have overcome this requirement of a trip to the patient's beside to reset the signal.

It is important to consider the patient carefully in the installation of any equipment he will use. It is important also to keep the operation of equipment as simple as possible, and the number of gadgets the patient will operate down to a minimum. It is difficult for a seriously ill patient to keep in mind that he must press a switch to talk, and release it to listen. The same reasoning would apply to the buzzer which the patient operates in the previously described system.

There are some two-way voice communication systems in use in which the patient's microphone and speaker are mounted on a portable pedestal type of construction. The patient presses the call button, which sounds a buzzer at the nurses' station and also turns on a signal light which identifies the room calling. The dome light in the corridor above the doorway to the room also goes on simultaneously. Hearing the buzzer, the nurse at the station snaps the talk key which permits conversation with the patient. The master unit is equipped with an earphone which may be used for confidential conversation. Lifting the earphone automatically cuts out the loud-speaker.

This system has many advantages especially regarding reduction in nurse traffic and in dispatching the proper person to answer the call. The chief disadvantage is where the automatic reset feature is lacking, making it necessary for a member of the nursing staff to travel to the bedside to reset the signal. There are also objections regarding the buzzer noise and movable equipment in the patient's room.

REQUIREMENTS OF GOOD SYSTEM

Following a study of the various types of patient-nurse communication systems and considering our current problems, we decided upon certain features which a system must have in order to be satisfactory. It must:

1. Be simple to operate.
2. Be quiet or free from irritating features.
3. Permit prompt acknowledgement of the patient call.
4. Save nurse traffic.
5. Permit better and more efficient use of ward nursing personnel.
6. Provide the nurse or doctor with a means of acquiring immediate assistance when required without leaving the patient's bedside.
7. Be dependable with a minimum of maintenance.
8. Be acceptable to patients, doctors and nurses.

The two-way voice communication we selected met all these requirements.

Some administrators have felt that audible communication systems might encourage patients to make greater demands on the nurses' time. We have found, however, that the effect of a thoughtfully chosen and reliable signaling system embodies a psychological component. When a patient is assured that the nurse can be summoned at any time with certainty, groundless fears have little opportunity to arise, and calls for attendance decline.

A dependable system also relieves the nurse of much anxiety in leaving the bedside of a seriously ill patient to care for others. A good communication system can be one of the best tools of good patient care on the ward and is coming to the fore even more with the rapidly mounting problem of nursing staff shortages.

A detailed explanation of the system installed at St. Luke's will be presented in these pages in the November issue.

Hospital Elevators

Finding and Keeping Employes

GLADYS BRENNAN
Executive Housekeeper, Methodist Hospital
Sioux City, Iowa

REGARDLESS of the size of an organization or the nature of its business, the foundation on which the personnel program is built is dependent entirely upon good employe relations.

We, the housekeeping administrators, must adjust our thinking about the people with whom we work; we must realize that one of our most important merchandising responsibilities is to sell our employes the idea that they are not domestics but business men and women who are engaged in producing a service which the public wants and must have. No public institution could possibly exist without workers of this type.

The relationship of personnel to the hospital is a vital subject which covers a wide area. It behooves us to seek and find the best people possible for the work to be done. With few employes available and with many of these inexperienced, the problem of quantity and quality from workers already on the pay roll becomes increasingly important.

WHAT MAKES WORKERS WORK?

An experiment conducted by the Western Electric Company in Chicago gave valuable data on the important question, "What Makes Workers Work?" The controlling factor in work production, the experts concluded, was mental attitude; also the fact that each employe wanted to feel needed and important. As Dr. Donald A. Laird, an industrial psychologist, says: "The worker brings only his ability to work, and the company is responsible for his attitudes."

From a paper presented at the Upper Midwest Hospital Conference, St. Paul, May 1952.

One of the first requirements for success in selecting anything is to know, as nearly as possible, what is wanted; the selecting of employes is no exception. Probably more than half of the errors made in personnel selections are due (1) to a failure to determine carefully, in advance, what traits are important, and (2) to make full use of such information when it is obtained. The person in charge of hiring should suggest detailed practical methods that a supervisor can use to prepare workable job specifications. She should also determine what the applicants are seeking in a job.

In carrying out the first responsibility of developing sources of labor supply, the executive housekeeper or personnel manager must not only keep in touch with the obvious sources, such as the local U.S. Employment Service and schools, but she must also make the hospital known in its community as a good place to work. One of the best methods open to anyone hiring workers is to help create a group of satisfied employes within the hospital who will recommend it to their friends and acquaintances who are seeking employment.

Another means is to conduct vocational tours through the hospital for young people as a part of the school curriculum in the community. Some of the larger industrial plants use lectures and motion pictures to impress upon prospective employes the satisfaction and advantages of working in their plants. Hospitals could well adopt the same practices.

PROMOTING FROM WITHIN

Still another important consideration in connection with developing sources of labor supply, and I can't stress this strongly enough, is a fact greatly emphasized by leading authorities that the first and best source lies within the organization itself. Promotion from within is a policy that deserves to be practiced whenever possible. Under such a plan employes become excellent salesmen because they then will emphasize the advantages and minimize the disadvantages. Nearness to the hospital, the companionship going to and from work, and an understanding attitude toward the new worker are assets the hospital can offer. Friendly relations means happy employes, something which money cannot buy.

Former employes constitute excellent sources of supply because their capacities and interests are known, and they have received training already in hospital policies and in certain duties.

Newspaper advertising reaches the greatest number of people seeking employment. In writing a newspaper ad, the terms defining the vacancy should be correct and the substance of the advertisement should emphasize all the advantages, such as five-day week, paid vacations, sick leave, uniforms

A true test of Quality

"How well will your sheets withstand the terrific abuse of the constant laundering required in institutional use?" This is an important question asked by every large institutional sheet buyer.

In reply, The Utica and Mohawk Cotton Mills are proud to offer significant assurance: the Certified Washable Seal awarded by the American Institute of Laundering, the National Trade Association of the laundry industry.

The presentation of this seal read:

"In behalf of the entire laundry industry, we of the American Laundry Institute wish to congratulate you and express our sincere pleasure concerning the way in which Hope Sheets, Mohawk Sheets, Utica Sheets, Mohawk Combed Percale Sheets and Utica Beauticale Sheets passed our very rigid inspection and testing."

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furnished, steady employment, and hospitalization. However, I sometimes think that the most undesirable people answer newspaper advertising, including floaters—people who work for a week or a month and then quit. Then there are individuals who do seasonal work in packing plants and seed houses for three or four months a year and then are out to find work until these plants reopen. These aren't good prospects when a hospital is looking for permanent workers.

Trade journals offer a good medium when persons having supervisory experience are needed. Newspaper advertising in suburban communities or near-by small towns often produces good results. Church homes, rehabilitation centers and welfare agencies interested in the welfare of the slightly handicapped are also sources of supply for some types of work.

Some very fine women and men are now on the pay roll of Methodist Hospital, Sioux City, Iowa, who just walked into my office, not knowing just what sort of work they had in mind. One woman with a good background in many other fields came to see me one day. I asked her why she came to a hospital to look for a job. She answered: "Because I know there will always be hospitals, good times and bad."

I should like to add that the most difficult jobs to fill are those for women who are needed in the laundry. Applicants seem to have the idea that laundry work is about at the bottom of the list in industrial prestige, yet about 65 per cent of all women are laundresses in varying degrees. The housewife places little stigma on doing a weekly wash. In our recruitment of laundry personnel a comparison of method might eliminate any prejudice. We have found that it works out very well to hire women who have had no experience and train them in our standards of work.

The amount of time consumed interviewing a prospective employe should be of no importance. However, as the saying goes, it should be like a woman's dress, "long enough to cover the subject yet short enough to be of interest." The greeting should be warm and friendly. The entire analysis of each party's expectations concerning the work, wages, increments, living quarters, advantages and benefits should be covered completely and discussed openly and honestly. The advantages should be greater than the disadvantages, the biggest of the latter being the necessity of having to work. This, of course, is accepted, but it is wiser to alternate the good and bad rather than list all the good and follow with all the bad. That way, many of the bad points will be more than neutralized by the good ones that are brought out.

A small handbook should be given each new employe so that he may be familiar with all hospital policies. He also will know what the hospital expects of him and he in turn will know what to expect from management.

In my opinion all employes should be in uniform; it does something to their morale and at the same time acts as a badge of service. We feel proud when we see our service employes step out on the floors in the early morning in their fresh starched uniforms. The housekeeping aides wear aqua dresses with white collars and cuffs; the charwomen wear soft gray with white collars and cuffs; janitors and housemen wear tan shirts and trousers; all laundry workers wear white, as do the entire dietary and kitchen staffs.

SOME BASIC CONSIDERATIONS FOR THE

CONTROL of STATIC SPARK

IN HOSPITAL OPERATING SUITES

A Statement to Architects, Hospital Authorities and Contractors

In an effort to clarify the matter of static spark control in Hospital Operating Room Suites, we present the following considerations which warrant the attention of every individual responsible for, or interested in, hospital safety.

That the hazard of static spark explosion exists, there is no question. There is some difference of opinion concerning the manner in which this hazard should be controlled. The operating room floor is, and has been long regarded as, the ideal medium for combating this hazard. However, the floor has recently become the means by which it is sought to control the hazard of electric shock *due to faulty electrical equipment.*

To simplify the issue, therefore, it may be said the floor can be used to perform the following functions:

1) **To ground personnel and equipment in operating rooms, thus helping to equalize electrical potential and prevent the formation of static sparks.**
2) **To insulate personnel in the operating rooms to preclude the possibility of electrical shock due to faulty equipment.**

Since these two purposes are opposed to each other, we conclude and maintain that one cannot be achieved without affecting the other.

Further, we maintain that grounding of the floor is by far the most important function of the two because—

1) **The static spark is more prevalent, more elusive and, therefore, harder to control than the shock hazard.**
2) **Any floor (even wood) when *wet* is very conductive and gives little protection against shock.**
3) **The hazard of operating room explosions caused by static spark heavily outweighs that caused by electric shock.**
4) **The electric shock hazard can, and must, be controlled by complete compliance with National Electrical Codes and strict maintenance of all operating room equipment.**
5) **Floors embodying elements of electrical *resistance* are not usually stable as regards conductivity, and many of them are impractical for operating suites from a viewpoint of maintenance, wear, appearance, and color.**

Believing, therefore, that an adequately grounded floor is most practical for operating

suites, we submit the following specification for use by architects and hospitals to achieve maximum static spark control in operating rooms.

SPECIFICATIONS

Hospital operating room suites shall have adequate provision for the control of static electricity by the use of grounded metal grids. These grids shall be made of 14 B&S gauge (1/16") brass or zinc, assembled to insure positive contact within each section. Individual sections of grids, and smaller sections where needed shall be fabricated in the shop to fit the job measurements. Sections shall have strips spaced to give maximum surface contact of 1½". These sections shall be assembled at the job.

Sections shall be joined by the contractor at the time of installation by brass bars, nuts and bolts, not soldered. Thresholds at door openings separating corridors or rooms having grids should be provided with similar grids so that there is no space more than 2" without grids. Thresholds shall be electrically connected by means of copper wire to the major portions of the grids. A heavy gauge copper wire, soldered to a metal strip and to a water pipe, is used to ground the grid.

All conductive rubber casters, knobs, etc., as well as brass or bronze chains used for contacting the grids shall be cleaned daily with alcohol. This cleaning is required to remove any foreign matter which might have accumulated during the course of an operation and which might prevent good electrical contact.

SUMMARY

The advantages of a floor constructed in accordance with the above specifications are:

a) It controls the static spark hazard by the grounding of operating suite equipment and personnel.

b) It retains its assured conductivity for life and is unaffected by wear, washing, or maintenance, or by occupational hazards peculiar to an operating room.

c) It is designed for long life and freedom from replacement or repair.

d) It is highly nonabsorbent.

e) It can be maintained economically and quietly.

f) It is adaptable to any color scheme desired.

g) Its performance is proven by the fact that there are about 2,000 hospitals in the United States at this time that have grounded grids in their operating rooms.

Any single one of the above attributes is highly desirable in an operation room floor—grids alone make available the combination of all these qualities.

Your earnest consideration of the foregoing is urged, along with any action which may be appropriate.

For further information, write:

NEWS DIGEST

Commission Defends Staff Meeting Standard . . . Pathologists Define Ethical Hospital Relationship . . . A.H.A. Proposes Institute of Hospital Affairs . . . Science Editor Challenges Doctors' Ethics

Accreditation Commission Defends Staff Meeting Standard Attacked by "GP"

CHICAGO.—In an editorial aimed at eliminating "unnecessary" hospital staff meetings, the magazine *GP*, official journal of the American Academy of General Practice, characterized staff meetings as "the least essential and productive" of medical meetings and urged doctors to take steps to eliminate them.

"The American College of Surgeons doesn't impose any such requirement (monthly staff meetings) for approval," the magazine stated. "Anyway, the American College of Surgeons is no longer in charge of hospital approval; it's been taken over by the Joint Commission on Hospital Accreditation. And they haven't said so."

Actually, present college requirements, according to the A.C.S. manual of hospital standardization, call for either a monthly staff meeting or, as an acceptable alternative, departmental conferences and clinical-pathologic conferences monthly, plus quarterly meetings of the entire staff.

Dr. Edwin L. Crosby, executive director of the new Joint Commission on Accreditation of Hospitals, said that at the present time commission standards for accreditation are the college standards as set forth in the manual, including the provision for monthly staff meetings or the alternative of monthly departmental or clinical-pathological conferences. This standard will remain in effect, Dr. Crosby stated, until any proposals for change have been fully studied and approved by the full commission.

While the commission has received a number of letters requesting modification of the hospital staff meeting requirement, Dr. Crosby said, no action could be taken on any such proposal until an official committee of the commission can be organized to study the problems involved.

Many such letters have come from physicians who serve on the staffs of several hospitals in their communities and are thus required to attend hospital staff meetings a number of times every month, Dr. Crosby explained. In the *GP* editorial, doctors were described as being "sick and tired of the multitudinous medical meetings that intrude on family life, personal relaxation, and professional time."

"Why don't you do something about it?" the magazine asked its readers. "You can eliminate some of the unnecessary meetings in your community, if you'll make a beginning.

"Nearly everyone agrees that there are too many meetings. There is also agreement that the least essential and productive is the time-honored hospital staff meeting. Already a few enlightened medical communities have taken steps to eliminate unnecessary hospital staff meetings. Why not yours?

"Here's the way to do it: At the very first meeting of your county medical society this fall, ask for the floor, rise and read this editorial. Then move that a committee be appointed to survey the local situation and make recommendations. (Previously, you have arranged for a friend to second your motion and have told the president you want to be on the committee.)

"Once the committee is appointed you call in a member of each of the local hospital staffs and the various academies, study clubs, research groups, and mutual admiration societies that hold regular meetings. Get an agreement that none meet oftener than once every three months. Group pressure from those who agree will persuade those who are inclined to hold out.

"The first person who objects that you must have monthly staff meetings is asked to prove it. Who said so? The answer is no one. It isn't true. The American College of Surgeons doesn't impose any such requirement for approval. Anyway, the American College of Surgeons is no longer in charge of hospital approval; it's been taken over by the Joint Commission on Hospital Accreditation. And they haven't said so.

(*Continued on Page* 146)

Dates Announced for Two Human Relations Sessions

CHICAGO.—So successful was the Educational Conference on Human Relations held in San Francisco earlier in the year that the American College of Hospital Administrators has planned similar conferences for its fellows, members and nominees in the East and Middle West.

Dates for the New York conference are October 20 and 21 in the Hotel Statler. The Chicago dates are November 7 and 8, and the conference will be held at the Congress Hotel. These conferences are in no way duplicates of the ones held in Chicago and Atlantic City in 1951, the college announces.

Blood Bank Association Plans Annual Meeting

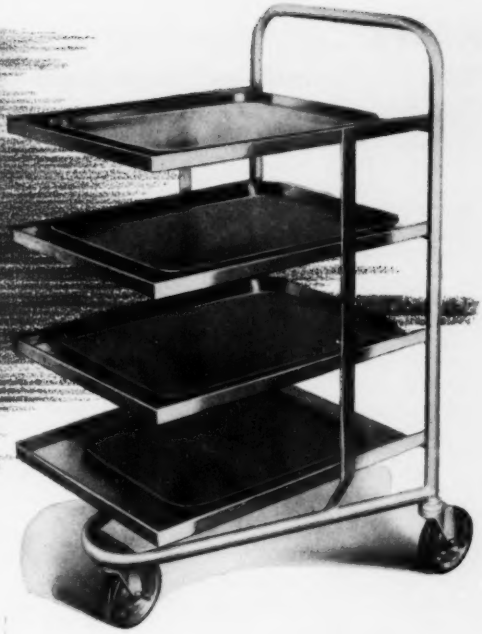
DALLAS, TEX.—Administrative and economic aspects of blood bank operation are scheduled for presentation and discussion during the fifth annual meeting of the American Association of Blood Banks at Milwaukee, October 9 to 11, Marjorie Saunders, association secretary, announced here last month.

In addition to clinical reports, the program includes a number of discussions on such subjects as coverage of transfusion cost in hospitalization insurance, blood typing, exchange of blood and blood credit among banks, the national blood program, medical legal problems in blood bank operation, and administrative problems.

A.C.H.A. Candidates Urged to Submit Requests

CHICAGO.—With the curtain barely rung down on the annual meeting of the American College of Hospital Administrators in Philadelphia last month, the credentials commission of the college will meet soon to consider candidates for advancement and admission to the college. Candidates therefore are urged to submit their requests at once in order to ensure consideration when the committee meets.

speedy tray service



. . . from floor that kitchens, heated tray trucks or tray-vyor stations. Four tray design insures that food will be HOT when delivered to patients' bed.

These service units conserve valuable space in corridors for they are designed to nest, when not in use, in any order and quantity. For example, while each unit is 25 inches long, each additional unit stacked adds only nine inches to the total space involved. The nested length of three units is 43 inches and that of five is 61 inches.

An added feature is the unusual caster arrangement. Mounted on three double ball bearing swivel casters with 5 inch ball bearing rubber tired wheels for easy rolling, this "Tri-caster" mounting causes far less spilling of soups and other liquids than the conventional four caster arrangement by reducing vibration to a minimum.

A test will readily prove to your satisfaction that these versatile units are a distinct improvement over equipment lacking these features.

These tray trucks are usefully employed in countless other hospital services, such as floor deliveries from pharmacy and central drug supply. MODEL 1358 has furniture steel shelves, aluminum bronze finished throughout, while MODEL 1359 is furnished with polished stainless steel shelves, aluminum bronze finished chassis.

SPECIFICATIONS

Length Overall	Width Overall	Height Overall	Shelf Size	Shelf Clearance
25"	21"	42"	16¼" x 24"	7"

Noiseless TRUCKS AND CASTERS

JARVIS and JARVIS, Inc.

PALMER, MASSACHUSETTS

NEWS...

Hospital Research and Educational Center Proposed; University Affiliation Sought

CHICAGO.—Favorable response to American Hospital Association proposals to establish an Institute of Hospital Affairs was indicated here last month as hospital administrators prepared to attend the association's annual convention at Philadelphia, where the proposals were to receive formal consideration by the House of Delegates (see Convention Digest, p. 51).

As presented in association publications, the plan would establish a research and educational center for the hospital field in connection with a midwestern university. The proposal was approved in principle by the association's board of trustees last June as a means of centralizing and expanding present association activities and developing programs, particularly of education and research, not now conducted in the field of hospital administration.

The proposed institute would require a physical plant to house education and research activities, it was reported. "Space would be available for the American College of Hospital Administrators and other groups affiliated with the hospital field that might wish to join in the utilization of central services," an association statement said. "The building would also provide facilities for research in better hospital operation, and, in general, would serve as a hospital administration clearing house."

To increase the educational value of the proposed institute, affiliation with a university is contemplated. "The university would be asked to establish a scientific committee to advise on the validity of research and educational activities," the association declared. "Through university affiliation, the staff of the institute would have the benefit of close association with the university faculty of the hospital administration program, as well as with the faculties of the schools of business, medicine, architecture, law and industrial relations."

The universities under consideration for affiliation for the institute were not named in association publications; however, it was reported that association officials had explored possibilities for institute development with both the University of Chicago and Northwestern University here.

"In considering the financing of an Institute of Hospital Affairs," the association statement concluded, "the board of trustees authorized informal discussions with a philanthropic foundation that has shown an interest in the association and its activities. The purpose of these discussions will be to determine whether the foundation might consider making a substantial grant to provide the necessary medical facilities and the financing of the institute program for a five-year period."

While initial reactions to the announcements were generally favorable, some administrators raised a question as to the status of the American College of Hospital Administrators if the proposed institute, with its expanded educational activities, were to become a fact.

Finance Commission Faces Four Big Questions

CHICAGO.—To the study of four problems, the Commission on Financing Hospital Care will devote a major portion of its resources, it was announced last month by George Bugbee, executive director of the American Hospital Association, sponsor of the commission. The problems are:

1. What are the elements of hospital costs and what factors affect these elements? Can hospital costs be reduced?

2. How can prepayment plans more effectively serve the public and the hospital?

3. What can be done to provide more nearly adequate financing of hospital care for persons receiving public assistance and social security benefits? How can the problems of financing hospital care for low income and rural families be met more satisfactorily?

4. What can doctors and hospitals do, working together, to bring higher standards of care to the public and at the same time keep costs as low as possible?

High priority on the list will go to a study of methods for determining the amount of payments to hospitals by third-party agencies. A study now under way deals with prepayment plan coverage of various population groups.

Studies contemplated deal with factors affecting costs of hospital care, prepayment plan benefits, utilization of prepaid protection, an evaluation of the entire problem of financing hospital care by public welfare agencies, and doctor-hospital relationships.

Tax Ruling Is Setback to Fee-Splitting Foes

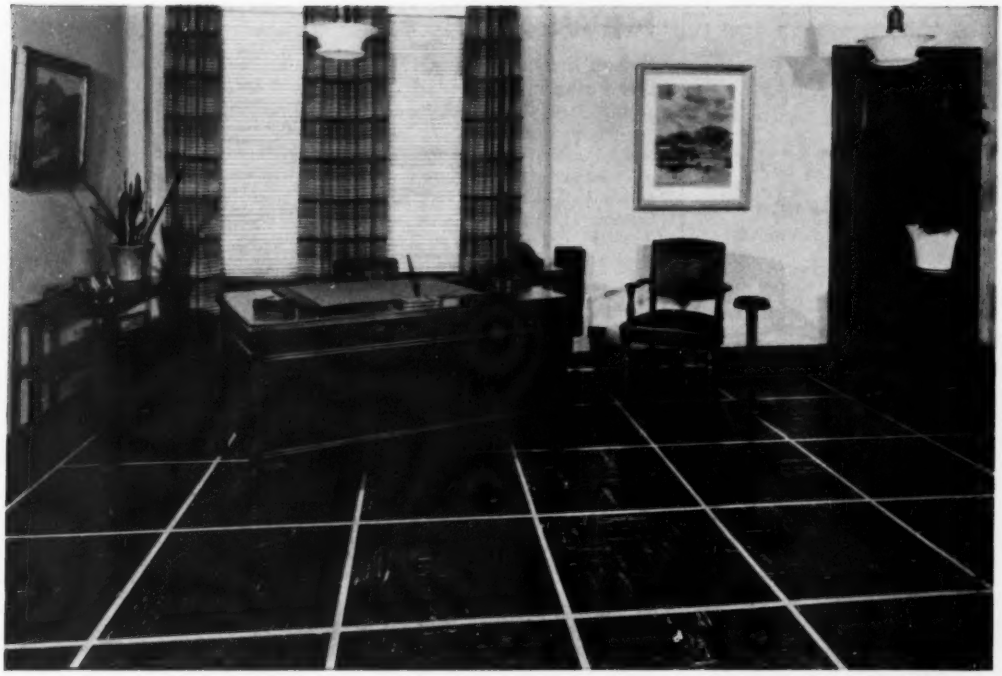
WASHINGTON, D.C.—A ruling issued by the Bureau of Internal Revenue here last month holds that the deductibility as business expense of "reasonable payments made by a surgeon on a split-fee basis to physicians who refer patients to him" must be determined in the light of all the circumstances in each individual case.

Actually, the ruling will not substantially change existing internal revenue practice, under which split-fee payments are either allowed or disallowed as deductible business expense on physicians' income tax statements according to the local collector's judgment as to whether or not such payments may properly be considered "ordinary and necessary business expense," considering prevailing practices in the community.

However, the ruling did constitute somewhat of a setback for the American College of Surgeons, the American Medical Association, and other voluntary organizations interested in combating fee-splitting. College officials had expressed hope that the bureau might issue a ruling indicating that all such referral payments should be disallowed as deductible business expense on the ground that fee-splitting is contrary to public policy as expressed in the ethical codes and statements of financial principles laid down by national professional organizations.

In contrast, the present ruling states that as a general rule referral payments are deductible for federal income tax purposes, provided they "are normal, usual and customary in the profession and in the community, are appropriate and helpful in obtaining business, and do not frustrate sharply defined national or state policies evidenced by a governmental declaration prescribing particular types of conduct."

Under this ruling, it is believed, split-fee payments will be disallowed in jurisdictions having specific laws against fee-splitting and in a few communities where professional societies have organized publicly to combat the practice.



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NEWS...

Rehabilitation Pays Off But Personnel Is Needed

NEW YORK.—The need for restoring patients' functional ability in addition to treating their disease was the main subject of discussion at the thirtieth annual meeting of the American Congress of Physical Medicine here recently. Physicians numbering 750 were from military and veterans' hospitals, mental hospitals, general hospitals, chronic disease institutions, tuberculosis sanatoriums, children's hospitals, various centers for rehabilitation, and for the treatment of cerebral palsy patients.

In-hospital rehabilitation services are at present hampered by a shortage of trained personnel and lack of facilities, although the number of physicians trained in physical medicine and rehabilitation has increased ten times over the number available before World War II.

Hospitals are becoming swamped with long-term chronically ill patients, speakers pointed out. Rather than invest large sums in domiciliary institutions they urged that money should first be spent on in-hospital rehabilitation services that will enable many patients to return to lives outside the hospital.

A year's experience with such a program in the chronic patient wards of Grasslands Hospital, Valhalla, N.Y., was described, showing that this new approach "pays off" economically and socially. Of the 58 patients who were looking forward to indefinite hospitalization, half of the group were walking without aid and two-thirds had been discharged to their homes. Of this latter group, two-thirds required less than 60 days of rehabilitation training to make them able to do for themselves.

Building Service Heads Start an Organization

NEW YORK.—Organization of a hospital building service association was announced following an initial meeting here last month.

Stated purposes of the association are to exchange information among building service executives in hospitals, to achieve recognition equal to that accorded other hospital service executives, to explore the possibilities for developing programs of employe training, and to achieve national standardization of equipment, procedures and executive titles.

After next January 1, membership applications will be welcomed from building service executives in New York, New Jersey and Connecticut hospitals, the group said; eventually, national organization status is anticipated.

Theodore E. C. Warren of the New York Hospital was named president. Other officers are Myrtle Ryder of Mount Sinai Hospital, New York, vice president; Herbert J. Harte, Veterans Administration Hospital, the Bronx, secretary; and George Spicer, Montefiore Hospital, New York, treasurer.

Rural Health Measures Needed in South

RALEIGH, N.C. — Negroes, tenant farmers, and indigents in rural areas of the South are in need of more doctors and health centers, larger hospitals, and more participation in medical insurance plans. These facts were pointed out at a recent regional meeting of the President's Commission on the Health Needs of the Nation held here.

Dr. George F. Bond, a leader in rural health affairs in North Carolina, stated that today's shortage of doctors results from the disinclination of young physicians "to practice saddlebag medicine of the 18th century." Rural area citizens, he said, must be educated to recognize their health needs so that they may build hospitals, either with or without the aid of federal funds. It is up to physicians to lead in educating them.

According to J. Street Brewer, president of the North Carolina Medical Society, these rural citizens of low income status require medical and hospital insurance at a cost they can afford to pay, either in the form of credit or cash supplied by landlords, bankers or others. The Negro cannot be dealt with as a separate entity in the population, he said.

Dr. Robert P. Daniel, president of Virginia State College, who also emphasized the shortage of hospitals for Negroes, said that scholarships for medical education for Negroes and the opportunity for Negro physicians to qualify for membership in the American Medical Association, through their county and state societies, should be provided.

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Staff Meeting Standards Defended

(*Continued From Page 142*)

"Then you report to the county society that the thing is done. And the next night you stay home with the family."

According to a report in the current issue of the *Bulletin of the American College of Surgeons*, the matter of medical staff meetings has been the subject of much discussion recently. "As a means of possible relief for the situation," the college *Bulletin* says, "the Manual of Hospital Accreditation states that, in well organized and departmentalized hospitals, departmental conferences and clinicopathologic conferences may be substituted for meetings of the entire staff, provided that all of the medical work of the hospital is covered by one or another of such conferences and provided that at least one meeting of the entire active staff is held during each quarter of the year. It is expected that if the alternative is adopted by a hospital, the departmental and clinicopathologic conferences will be held at least monthly throughout the year and that the quarterly meeting of the entire medical staff will be devoted to a résumé of the departmental and clinicopathologic review during the previous quarter. It is expected, also, that complete and detailed minutes of the conferences at the departmental level, as well as at the quarterly meeting, will be kept and that an average attendance of at least 75 per cent at the conferences and meetings will be maintained during the calendar year."

According to Dr. Crosby, this states the existing standard as approved by the accreditation commission.

Nurse Shortage Hits Home as Polio Mounts

CHICAGO.—Nursing personnel problems were striking home with compelling force in hospitals throughout the country last month as the 1952 polio epidemic mounted to near-record proportions. In mid-September, Basil O'Connor, president of the National Foundation for Infantile Paralysis, said here at a conference of foundation leaders that incidence this year was 76 per cent higher than the case count for the same period in 1951, and 4 per cent higher than the incidence in 1949, when the nation had its worst polio year.

A report from the U.S. Public Health Service listed Illinois, with more than 300 cases, as the worst polio state. Other states experiencing severe polio outbreaks were Michigan, Indiana, Ohio, Texas, California, Wisconsin, Minnesota, Iowa, Missouri, North Dakota, South Dakota, and Kansas.

One of the worst states of all was Nebraska, with an infection rate of 83 cases per 100,000 of population. According to Nebraska hospital administrators, the polio problem had become all but unmanageable by the middle of September, with many hospitals flooded with polio patients and unable to employ enough nurses to keep abreast of patients' needs.

In Lincoln, for example, at the beginning of the epidemic one of the city's hospitals was designated as the polio center; facilities for treatment were concentrated there, and all patients were referred to that institution.

in accordance with accepted practice, as soon as the diagnosis had been established. Quickly, however, as it turned out, this hospital was filled to capacity, and other institutions were accepting overflow cases.

Soon these hospitals, too, were filled up with polio patients. "Even by canceling surgery and restricting admissions to emergencies only," said Donald Duncan, business manager of St. Elizabeth's Hospital, "our nursing staff was unable to keep up with the demands of the polio patients, and all hospitals were in the same situation."

As a matter of fact, Mr. Duncan reported, many nurses, frightened by the epidemic, won't work on polio floors.

"Under the circumstances, we must not condemn the nurses for taking this attitude," Mr. Duncan explained. "We must remember instead that many of these nurses have homes and children of their own; they cannot be sure that working with polio patients in the hospital will not endanger the health of their own families. Many nurses said to me, 'My husband won't let me work if I am assigned to polio cases.'"

Much the same situation was reported from hospitals in other parts of the country where severe outbreaks were in progress last month. One favorable sign was that the death rate, which has approximated as much as 10 per cent of the number of cases in previous epidemic years, was running substantially below this level in most of the 1952 outbreaks.

Business Publications Observe ABC Month

CHICAGO.—October has been proclaimed ABC month by many business publications.

"The MODERN HOSPITAL has been minding its ABC's ever since the magazine was founded nearly 40 years ago," declares Stanley R. Clague, a director of the Audit Bureau of Circulations. Mr. Clague is secretary of the Modern Hospital Publishing Company, Inc., which was a charter member of the audit bureau, and which publishes the *Hospital Purchasing File, The Nation's Schools,* and *College and University Business* as well as THE MODERN HOSPITAL.

"The masthead of 370 business periodicals, representing a combined circulation of approximately five million, carries this information, 'Member, Audit Bureau of Circulations.'"

The story of the audit bureau is the record of a successful adventure in integrity dating back to 1914, Mr. Clague reports. Prior to that time there was no generally accepted means of measuring or verifying a publication's circulation. Recognizing that both readers and advertisers are entitled to verified facts on the paid circulation of a publication, a group of publishers and advertising men formed a cooperative association, which has operated since that time as the Audit Bureau of Circulations.

The audit bureau has experienced auditors who make annual audits of the circulation records of each publisher member. The reports establish circulation standards which publishers can use in answering such questions as: Who reads the publications? Where does it go? How much do people pay for it?

Science Editor Challenges Ethics Committees

CHICAGO.—Objectives sought by medical society public relations committees frequently conflict with restrictions imposed by society judicial councils, Arthur J. Snider, science editor of the *Chicago Daily News,* told an institute on medical public relations here last month.

Mr. Snider spoke at a panel discussion during the institute, which was sponsored by the American Medical Association.

"About three years ago," Mr. Snider related, "the American Medical Association laid down an enlightened, progressive policy on ethics. But apparently the constituent medical societies are having difficulty in putting it into operation." The speaker told of several episodes in which constructive newspaper stories about doctors were blocked because the ethical relations committees of the medical societies took the view that any publicity naming an individual might give him an "unfair competitive advantage."

Public relations committees of medical societies are trying to do a good job, Mr. Snider said, "but they are

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hamstrung by the ethical committees which hold powers of penalty. If the decisions of the ethical relations committees are based on the unfair competitive advantage publicity gives a doctor, then why are research men hailed before these committees? Why is a doctor's name permitted in that excellent magazine, *Today's Health*, and not permitted in newspapers that have a greater reading public? Why is it perfectly okay for a doctor to write a book for the general reading public, when he is not permitted to be quoted in the daily press? Why is the American Medical Association's publicity department permitted to send out releases using doctors' names without clearing with the ethical relations committees, as newspapers must? Why is it all right for some doctors to appear on television, and others not?

"Why is it that the names of medical organizations and medical political leaders can appear in the press with impunity, and the doctor slugging it out on the research line and paid a meager salary is hailed before the ethical relations committee when his name appears in the papers?"

Citing the case of a plastic surgeon who was called before the ethical relations committee of his medical society because a story about his charitable work at a state penitentiary had appeared in the newspapers, Mr. Snider pointed out that the ethical relations committee had condemned the doctor even though he had nothing to do with the display given his story by newspaper editors.

"In a day when doctors are maligned on all sides for fee-splitting, high fees, unwillingness to take Sunday and night calls," the speaker asked, "is a story about a doctor who devotes one day a week to a unique kind of charity a credit to the profession—or does it do harm to the profession, as the ethical relations committee believes? I leave the answer to you public relations people."

In other presentations to the institute, public relations programs being conducted by county and state medical societies were described and studied in detail. Many speakers emphasized the fact that public relations problems of the medical profession today must be resolved by individual doctors in their own offices and hospitals and through action of local medical societies, rather than solely through national publicity.

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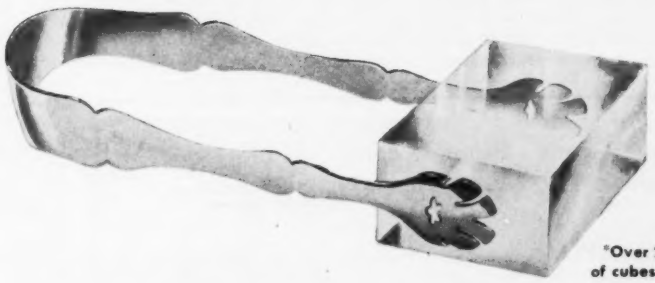

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NEWS...

Opinion Survey Leads to Several Recommendations About Charity Hospital

NEW ORLEANS.—Charity Hospital's reputation for superior medical care is so great that many patients are sent here from remote parts of the state when they might easily be given adequate, economical care at home, a survey of the 3000 bed, state operated hospital here indicated last month.

Some overcrowding also is caused by the fact that many patients able to pay for their care are included on the hospital's charitable rolls. Because of the tremendous case load carried by the hospital, the survey indicated, the staff of social service investigators assigned to the task of checking patients' eligibility for admission and free medical care is able to investigate only the "more suspicious cases."

A study of approximately 30,000 admissions on which social service investigations were conducted in 1950-51 revealed 26 per cent were ineligible for free treatment because their incomes were over the maximum established for charity service, the survey indicated.

These and other hospital problems were studied by New Orleans newspaper writers during a two-week survey covering interviews with professional and administrative personnel of the hospital. Following their opinion survey, the newspaper men recommended a zoning system for the state under which charity care would be rendered by hospitals in various parts of the state instead of only at the Charity Hospital here.

The surveyors also proposed that a custodial hospital be established to care for state aid cases requiring lengthy treatment, that state funds be provided for home care of many patients in classifications now referred to Charity Hospital, that the hospital's admitting procedure be speeded up by the employment of several full-time admitting room physicians, and that increased wages and improved personnel programs, including a civil service or merit system to protect jobs, be established to relieve the shortage of hospital workers in all classifications.

The investigators found, however, that many complaints about the handling of admissions, particularly in accident and emergency wards, were not justified. "The emergency department is considered among the finest in the nation," their report stated. "Those persons who are financially able to pay for medical care and not badly injured are patched up and directed to private hospitals. They can't understand this procedure. They have the idea that Charity Hospital is their hospital, when actually it is meant for the poor."

Complaints about admissions were among the reasons given for replacement of Dr. Robert Bernhard as medical director of the hospital, the report stated.

Another charge against the hospital was that doctors on the staff were using it for their own medical investigation and teaching purposes, instead of for the benefit of the indigent sick. Deans of the medical schools at Tulane University and Louisiana State University, both of which carry on research and teaching programs at the hospital, denied that this was the case.

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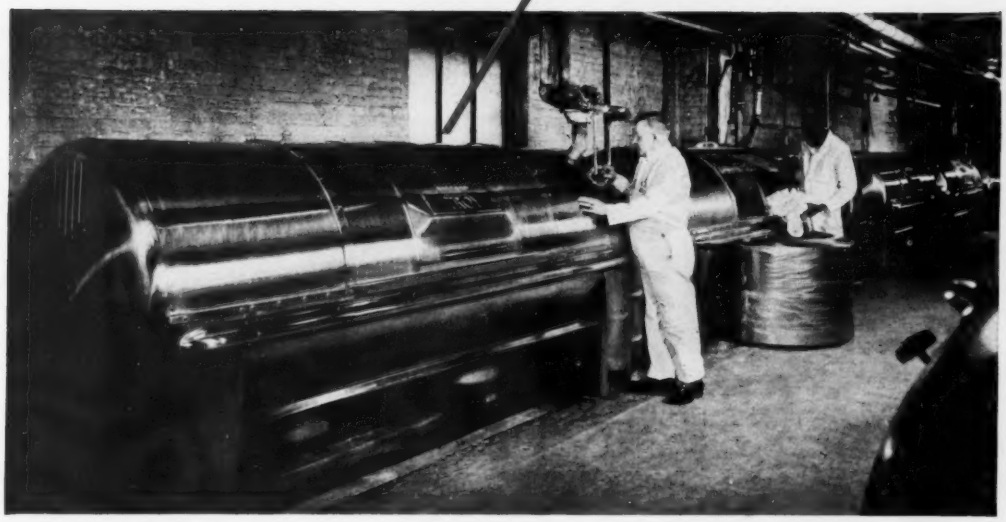

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students of medicine rebound to their benefit and at the same time promote the cause of medical science," Dr. William W. Frye, Louisiana State dean, told the investigators. "All types and conditions of patients must be given the opportunity to become beneficiaries as well as benefactors of medical advance. The public is beginning to realize that scientific interest in patients enhances the chances of better treatment of the sick."

Dr. Maxwell E. Lapham, Tulane dean, defended the hospital's 150 bed psychiatric section, which was opposed by critics who contended that mental patients should be treated elsewhere and these beds used for acutely ill, indigent, medical and surgical cases. Only through programs such as the one being carried on at Charity, he argued, can medical science progress in the restoration of many formerly "hopeless" mental patients to normal life.

Following their survey, the newspaper men also concluded that the charge of excessive use of hospital facilities for investigation and teaching was unjustified.

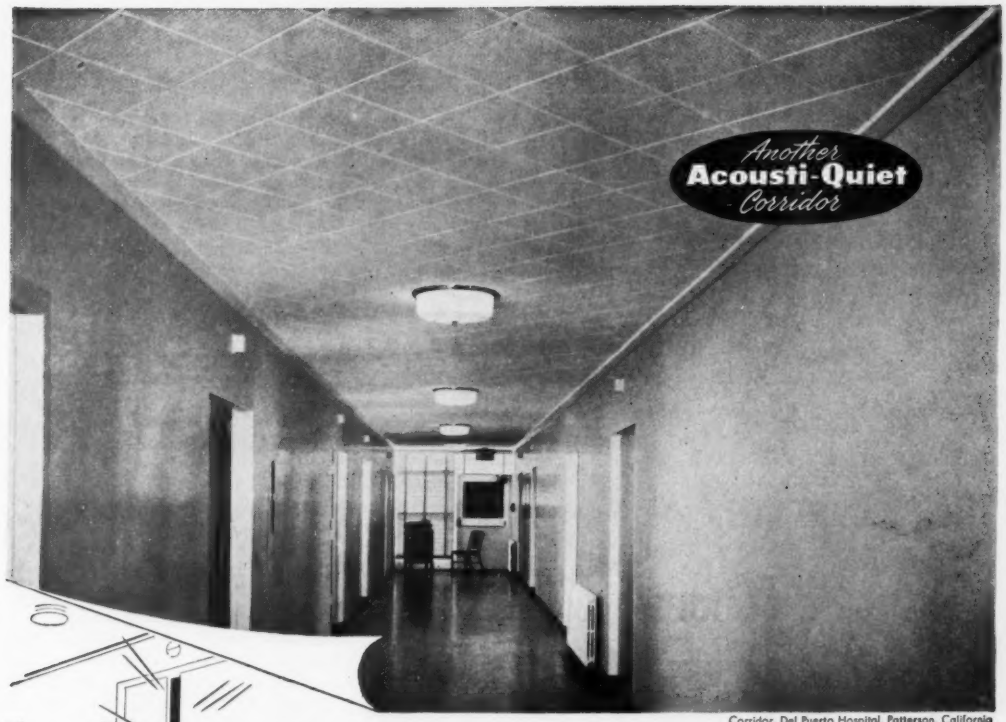
Surgical Dealers Reply to F.T.C. Price Charges

CHICAGO. — Suppliers of hospital and surgical equipment here last month were indignant about publicity in connection with Federal Trade Commission charges that the American Surgical Trade Association and the Manufacturers Surgical Trade Association kept prices up by shutting out competition.

Newspaper and newsmagazine reports of the F.T.C. action, surgical dealers claimed, left readers with an inaccurate impression of price and marketing practice in the field. One report, for example, had referred to markups "as high as 600 per cent" between manufacturer and buyer.

"Actually," said one representative of the dealer group, "the average profit on all lines handled by surgical dealers is only about 5 or 6 per cent. On any particular item, of course, there may be some good reason that a much higher markup is necessary. But it is wrong to leave the impression that any such price differentials are common or typical."

Following F.T.C. charges last spring that the associations were engaging in restrictive practices, a consent de-



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cree was signed in which they agreed to refrain from specific practices named in the charge.

While individual members objected to what they felt was harmful publicity, there was no indication here that the associations would release any official statement in reply.

Georgia University Offers Administrator Training

ATLANTA, GA.—The University of Georgia, Atlanta division, is offering a one-year certificate course in hospital administration beginning with the 1952 fall quarter, it was announced here last month.

The course will be conducted in evening classes for students with two years full-time experience in hospital administration who are qualified by aptitude tests and personal interviews, the university said. Academic credit for the certificate course will be contingent on the student's meeting the university's requirements, it was stated.

Following a year of evening classes, field experience covering a period of approximately six months in at least two hospitals will be required before the certificate is issued.

The training was especially designed to meet the needs of administration in smaller hospitals, the university said. "With the completion of more than 25 hospitals of 50 beds or less in Georgia, in addition to the 220-odd general hospitals already operating in the state," a university announcement stated, "the need for trained hospital personnel becomes increasingly insistent. The rapid growth in hospital population and the economic necessity for efficient operation of these institutions have combined to create a demand for personnel directly trained in hospital administration. This situation is acutely felt in the state of Georgia, and, undoubtedly, a similar situation is present in other states of the southeastern area."

Courses offered will include medical background for hospital administration, hospital organization and management, hospital equipment and supplies, accounting records and business practice, routine laboratory and x-ray technics, in-service training and special hospital projects, and hospital and community.

Members of the faculty include Dr. R. C. Williams, director of the division of hospital services for the Georgia State Health Department; Oscar S. Hilliard, administrator of the Athens General Hospital, and Harold O. Duncan, hospital administrator, who has served at George Washington University and Veterans Administration hospitals.

Say Patients Should Train Attendants

NEW YORK.—A new concept in rehabilitation training of the handicapped was advanced here last month by Dr. Morton Hoberman and Ebert F. Cicenia of the New York State Rehabilitation Hospital, who suggested that handicapped persons should be trained to help those on whom they are dependent for physical care.

In a presentation to the 30th annual session of the American Congress of Physical Medicine, Dr. Hoberman and Mr. Cicenia said hospital staffs in the past have attempted to train disabled patients to care for themselves, without acknowledging that many of them will always be dependent on other

NEWS...

persons for assistance in performing many daily tasks.

Such patients, they urged, should be trained to assist those who care for them. In addition, parents and others who attend severely disabled persons at home should be given training too.

The training need not be complicated. The patient could be taught ways to assist an attendant in helping him in and out of a wheelchair, to help himself be lifted from wheelchair to bathtub or car, to assist in dressing, and to help with other similar tasks. In turn, the parent or attendant could be taught ways of helping the disabled patient perform these tasks with a minimum of effort.

Spends $50,000,000 on Medical Care

WASHINGTON, D.C.—The United Mine Workers' Welfare and Retirement Fund provided nearly $50,000,000 in hospital and medical care benefits during the year ending June 30, 1952, a report released by the fund here last month revealed. The fund provided 2,154,882 days of hospital and medical care for 215,372 beneficiaries throughout the bituminous coal mining communities, it was reported.

"If all fund patients had received hospitalization at one time, they would have occupied every hospital bed in the United States for one week," the report stated.

The fund's proposed hospital construction program, a major development of the past year, was described in detail. "The medical staff of the fund had long but unsuccessfully endeavored to bring about improved and increased hospital and medical facilities and services in these areas," the report said, explaining the reasons for the program under which 10 hospitals are to be constructed in Kentucky, West Virginia, and Virginia. "Therefore, with the active and extensive cooperation of its medical advisory committee, composed of eminent physicians and hospital experts, the medical service of the fund submitted an exhaustive report of its findings on hospital and medical care conditions in these areas and their recommendations for the construction of hospital facilities as the only method by which satisfactory hospital and medical care benefits could be made available in these communities. Architects' plans

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NEWS...

are reported well under way, and construction of the 10 hospitals is planned to start during the coming fiscal year."

The unexpended balance of the welfare and retirement fund at the end of the fiscal year was $99,505,895, the report stated. Total expenditures for the year were $126,338,269; revenue collected from coal mine operators under the provisions of the national bituminous coal wage agreements was $125,734,818.

Issues Standard on Foam Rubber Mattresses

WASHINGTON, D.C.—A national standard for foam rubber mattresses is now available from the Commodity Standards Division of the U.S. Department of Commerce.

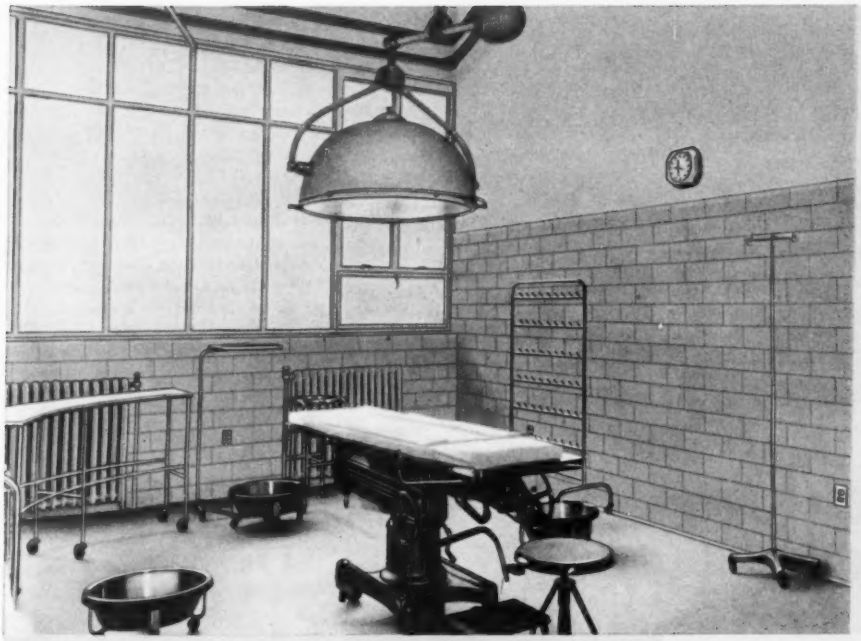
"This commercial standard provides a national recognized specification for the guidance of producers, distributors and users of latex foam mattresses," says Secretary Charles Sawyer. "It promotes fair competition and consumer confidence in foam rubber mattress products, and provides a basis for labeling and guaranteeing the quality of the product. It covers minimum requirements and methods of testing for one grade of latex foam mattresses made of either natural or the synthetic type of rubber latex."

Copies of the pamphlet, "Latex Foam Mattresses for Hospitals, Commercial Standard CS182-51," may be had from the Superintendent of Documents, Government Printing Office, Washington 25, D.C., for five cents a copy.

Hospital Consultants to Meet With A.A.A.S.

GREENVILLE, S.C.—Jacque Norman, secretary of the American Association of Hospital Consultants, announces here that during the annual meeting of the American Association for the Advancement of Science to be held in St. Louis during Christmas week the hospital consultants will hold an afternoon program. The date of the joint A.A.A.S. and A.A.H.C. meeting is December 29 at 2:20 in the afternoon.

The program is as follows: "Planning for the Basic Sciences in the Hospital," Dr. Basil C. MacLean; "Planning for the Mechanical Sciences in the Hospital," Dr. David Littauer; "Planning for the Clinical Sciences in the Hospital," Dr. E. M. Bluestone.



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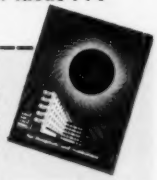

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NEWS...

New York Blue Cross Experiments With Visiting Nurse Service

NEW YORK.—Under a two-year experiment Associated Hospital Service and three cooperating hospitals will provide visiting nursing service to a limited number of Blue Cross members upon their discharge as hospital patients.

Lenox Hill, Brooklyn and New Rochelle are the three hospitals taking part in the experiment. Also cooperating are the visiting nurse associations of New York, Brooklyn and New Rochelle.

"Data accumulated during the two-year period will be studied to determine the feasibility of including visiting nurse service among Blue Cross benefits and to define the circumstances under which it may be provided," Louis H. Pink, chairman of the board of directors of Associated Hospital Service, New York's Blue Cross plan, declared early last month.

The experiment has been prompted by rising hospital costs. It is thought that provision of visiting nursing service might reduce the average length of time patients spend in the hospital. If Blue Cross members hospitalized in the Greater New York area during 1951 had left the hospital one day sooner, the over-all saving to Associated Hospital Service would have amounted to more than half a million dollars, Mr. Pink asserted.

Patients will be selected from private rooms, semiprivate accommodations, and wards on the basis of their need for nursing service after hospitalization. The need will be determined by the patient's physician, the hospital administrator, the nursing agency, and a nursing coordinator of the project.

Oak Ridge Hospital to Seek Uses of Atomic By-Products

KNOXVILLE, TENN. — Construction bids were requested here recently on the center-hospital that will seek peace-time uses of atomic energy by-products from Oak Ridge, Tenn.

A total of $6,000,000 has been appropriated to construct and equip the new building, to be called the University of Tennessee Memorial Research Center and Hospital.

The new center will contain general hospital facilities for 317 patients as well as research laboratories to use radioactive isotopes from Oak Ridge and special educational facilities to train medical personnel and scientists on the postgraduate level. While emphasis will be placed on atomic research, the center also will conduct medical research in other fields.

The building was designed by Baumann and Baumann, Knoxville architectural firm, assisted by York and Sawyer of New York and Washington.

Nursing Runs in Family

ALEXANDRIA, VA.—The great granddaughter of a student of Florence Nightingale's in England has enrolled as a first-year student at the Alexandria Hospital School of Nursing. She is Margaret Louise Wilding, 19, of Silver Spring, Md. Her mother was a nurse during World War I in St. Thomas's Hospital, London. Margaret's parents met in France where both were attached to the French army.

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NEWS...

Psychiatric Aide Course Established in Maryland

CATONSVILLE, MD.—A psychiatric aide course, unique in the history of nonprofessional psychiatric nursing, has been established at Spring Grove State Hospital here, the center for psychiatric aide education in Maryland.

Graduates of the course are fully prepared for teaching and supervision of nonprofessional nursing personnel.

Similar to the training formerly given psychiatric aides at the Menninger Sanitarium, Topeka, Kan., where emphasis was placed upon psychiatry and basic nursing, the course at Spring Grove includes ward administration and ward teaching as additional studies.

Initiated by George W. Mason, director of nursing service and nursing education, department of mental hygiene, the intensive course covers 385 hours of classroom work and 1700 hours of clinical experience under direct supervision.

Admission standards are based on high school attendance and ratings in aptitude and personality tests. State mental hospitals, within the department of mental hygiene, will send selected, qualified candidates to Spring Grove. Upon completion of the course, aides will return to their hospitals.

Through the efforts of Mr. Mason a classification and salary scale for psychiatric aides has been established as a recognized branch of the nursing services in all Maryland mental hospitals. The aides are paid $2160 during their training period and are advanced to $2400 upon graduation. Their maximum salary, after five years, is $3000.

Sister Mary Bede Is Montana President-Elect

BILLINGS, MONT.—Sister Mary Bede, administrator of Columbus Hospital at Great Falls, was named president-elect of the Montana Hospital Association at the association's annual conference here last month. Sister Mary Bede will succeed Harry C. Dunham, administrator, Memorial Hospital, Missoula, Mont.

Other officers named by the association were Edwin Grafton, Shodair Crippled Children's Hospital, Helena, secretary-treasurer, and Sister Mary Anthony, Kalispell General Hospital, Kalispell, trustee.

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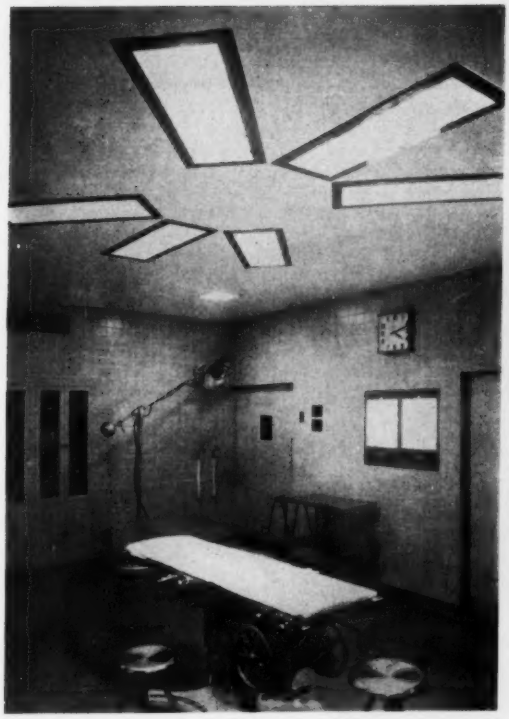

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NEWS...

Surgeons Hear Report on Activities of Hospital Accreditation Commission

NEW YORK.—A report on current activities of the new Joint Commission on Accreditation of Hospitals was presented at the annual clinical congress of the American College of Surgeons here last month by Dr. Gunnar Gundersen, chairman of the commission and a trustee of the American Medical Association. Dr. Gundersen said the commission's goal was to adhere rigidly to the high standards established by the American College of Surgeons in its hospital standardization program. "If we do this, we win," he stated. "If we do less, we fail."

Dr. Gundersen described the commission as "an established fact and a going concern." Relating the appointment of Dr. Edwin L. Crosby as executive director, he added, "It is my considered judgment that no more able person could have been found in the American hospital field than Dr. Crosby. He has proved his ability and fitness to undertake this work. We know he is interested in his job and will capably direct the movement. He has ability to work with others and will exercise calm supervision and good leadership, exemplified by enthusiasm, patience, energy, courtesy, interest and many other basic characteristics of an efficient executive."

Dr. Gundersen said the commission "takes great comfort in the fact that Dr. Malcolm T. MacEachern's services will be available for consultation and advice." He described Dr. MacEachern as "the dean of the hospital standardization workers."

BASED ON A.C.S. STANDARDS

The commission has accepted American College of Surgeons standards as the basis for inaugurating its own program, Dr. Gundersen reported, with the understanding that the program "in all likelihood will be modified as soon as the Joint Commission has had an opportunity to direct attention to the formulation of specific standards for hospital operation."

Commissioners recognize the importance of an early review of existing standards and adoption of a uniform inspection procedure, the chairman stated. The commission accepted its responsibility, he said, "with humility, conscientiousness and a determination in our hearts to carry on this great work which is unique in the history of the world." The commission realizes that hospital inspection and accreditation is not mere routine, Dr. Gundersen concluded.

"It is a voluntary movement representing the best thinking and the best inspiration of five of the most powerful groups in the world dealing with health," he declared. "We recognize what this will mean to the care of the sick and injured of Canada and the United States. We realize that this may eventually mean much to the care of the sick and injured the world over. If these duties are discharged well, the benefits to mankind through our profession, through our hospitals, and for our civilization are unreckonable.

"It is gratifying that here again the medical profession and hospitals are doing this idealistic task themselves with their own money and efforts. It is not a legislative or socialistic movement. It is entirely voluntary and an-

Mr. Snyder removes a sheet cake from a Garland 45-29 hot top range oven.

Extensive Tests Establish Outstanding Bakery Performance of Garland Range Ovens

A demanding series of baking tests and demonstrations were recently conducted as a part of Garland continuous research and development program. They offer dramatic proof that ovens of Garland ranges maintain a constant, uniform heat.

Bread, cakes, pies, rolls, delicate Danish pastry . . . all were baked to a turn, consistent from pan edge to pan edge. At the conclusion of the tests, Richard V. Snyder, Commercial Baking Instructor, Detroit, who conducted the tests, said, without qualification: "All types of pastry and bread products can be perfectly baked in the oven of a Garland range."

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other evidence of a grand work performed voluntarily on the part of our profession and hospital people. I feel it is the most important voluntary movement that could be undertaken."

Pathologists Warned Not to Solicit Hospital Positions

CHICAGO.—In the hope of lessening the number of complaints based on violations of Canon I of the code of ethics of the College of American Pathologists, the ethics committee has prepared an interpretation of the canon. It reads:

"'I shall not solicit, knowingly permit others to solicit in my behalf, nor shall I accept a position which is occupied by another pathologist without first consulting with that pathologist.'

"It is frequently true that 'for the physician the strictly scientific practice of medicine leads often in one direction, the conditions of remuneration in another.'* In professional circles, competition for a situation should be conducted with frankness, amicability and with a dignity that is fitting the highest of callings; it should be without slyness or subterfuge. To reserve our major thoughts and energies for scientific endeavor, to the ultimate welfare of the patient, our professional life should be free of the fear of continual secretive competition. It would be most unfortunate if those who are not pathologists can force upon us subjugation to competition by conspiracy. This canon defines the courtesies and amenities of professional competitive relationship, by application of the Golden Rule.

"The word 'solicit' implies an intentional, self-determined profferment of services. A pathologist is soliciting when he offers his services by proposal or application to executive or administrative authority. In a hospital such authority can be the chief of staff, the executive committee, the president, or a member of the board of trustees or the administrator.

"The insertion of the clause, 'knowingly permit others to solicit in my behalf,' is obviously meant to discourage an aspiring pathologist from making an oblique or subtle solicitation through a third party in an attempt to disguise the proposal he has

*Fite, quoted in Percival's Medical Ethics.

NEWS...

originated or accepted. Frequently a pathologist will be considered as a replacement without his knowledge. Once such a proposal becomes known to him he shares equally in the responsibility for it.

"It would be preferable if the canon were worded so as to apply equally to an incumbent and to the pathologist who has recently been the incumbent of a position. It is regrettable that there have been conspiracies between aspiring pathologists and representatives of hospitals to the end that the aspirant's proposals and intent are kept secret and undisclosed until the incumbent is relieved of his position. This is shrewd and close practice which violates the spirit of Canon I. The ethics committee of the college agrees that such an evasion be adjudged a violation.

"A change in management or control, actual or impending, whether or not it involves a change in name of the institution, does not relieve a pathologist from his obligation to consult with the incumbent pathologist. Neither does an expressed determination to alter the type of relationship between incumbent and institution—formal, contractual or informal—affect his obligation in this regard.

"The responsibility of a pathologist who desires to apply for a position held by another, or who finds himself offered such a position, extends only to first 'consulting with that pathologist.' The consultation must include notification of intent by the aspiring pathologist and it definitely implies a bilateral exchange, affording the incumbent pathologist an opportunity to express both his attitude and the circumstances of his situation.

"The aspiring pathologist is likely to overlook the benefits of this consultation. Administrators, boards of trustees, staff executive committees and our clinical brethren have been known occasionally to impose difficulties and unreasonable limitations upon a pathologist's position. Such features may not be apparent when the situation is first described. The incumbent pathologist will frequently disclose such problems with reasonably unprejudiced truthfulness. The warning of a long suffering incumbent could be the only defense an aspiring pathologist might have against perpetuating an intolerable situation.

"On the other side, this canon as-

NEWS...

sures that the incumbent pathologist gets reasonable notice. There have been situations in which a pathologist, competent and acceptable to the majority of his staff, has had his position secretly undermined by an unsympathetic minority. Perhaps only the merest warning is necessary to give a competent and faithful confrere the support of a sympathetic majority.

"There have been others who have tried to use this canon as a shield against the inevitable result of incompatibility and incompetence. The canon in no way guarantees tenure to the incumbent. Patients and physicians have the right to expect capable, competent and courteous performance. The canon is not meant to expect resistance to the replacement of a pathologist who is persona non grata with the majority of physicians with whom he should cooperate. It cannot be invoked to deprive the patients in a hospital of the services of a new pathologist who is acceptable to the staff.

"The aspiring (and often younger) pathologist has occasionally misunderstood the intent of this canon, feeling that it imposes a limitation upon free enterprise. It is noteworthy that the canon states no obligation beyond that first consultation. From that point on the aspiring pathologist is free to make his own decision and to conduct himself as his prudence dictates. This canon in no way inhibits free enterprise or the creation of opportunity; it merely defines the manner in which it should be pursued.

"Perhaps it would not be amiss to touch upon the details of the manner in which this canon can be observed, when an initial or preliminary inquiry convinces an aspiring pathologist of the desirability of a situation already occupied by another. Before he proceeds further in his official discussion or overtures he is obligated to contact the incumbent pathologist. This contact can be by any means which will offer a bilateral opportunity for expression and can be by telephone, letter or personal meeting. Telephone conversations are apt to be misunderstood and leave no tangible evidence of their execution. It is strongly recommended that the 'consultation' be by personal interview and subsequently confirmed by letter. Such evidence of considerate conduct 'stands for all the world to see.'"

Refresher Courses for Inactive Nurses

NEW YORK.—An attempt to interest New York City's 5000 nurses, who are either inactive or prematurely retired, in resuming their professional activities is being made by Dr. Marcus D. Kogel, hospital commissioner.

A series of refresher courses is being offered in the municipal hospitals, the first of which was started in September at Queen's General Hospital. Others are to be given during October at Bellevue Hospital, Kings County Hospital, and Morrisania. All are designed to acquaint nurses with the most recent developments in nursing and to assist them in regaining skill and confidence. The developments within the last five years have left the currently inactive nurses far behind. The refresher courses give them a chance to catch up and provide them with an opportunity to enter the city system at a base salary of $2950 and to have the advantages of a pension system, vacation and sick leave, plus unlimited opportunities for advancement.

Of the 7351 positions for registered nurses in New York municipal hospitals only 3598 are at present filled.

Calls Sickest Patient Mental Hospital V.I.P.

NEW YORK.—Today the most important person in the hospital, particularly the mental hospital, is the sickest patient. Not so, not so long ago.

Dr. Arnold A. Schillinger, chief of professional services at Veterans Administration Hospital, Montrose, N.Y., drew the foregoing contrast in speaking before the American Association of Rehabilitation Therapists, which met here last month.

Under the old system, the superintendent was the most important person in the hospital. A hospital was dominated by a sort of order of authority with doctors and nurses at the top and untouchables, who washed dishes and mopped floors, at the bottom.

A new team system has replaced that order, Dr. Schillinger told the rehabilitation therapists. Trained therapists of many specialties must work together, pooling their technics, in order to provide the full measure of treatment for each patient, with emphasis on the sickest patient.

NEWS...

Explains Autopsy Precautions Following Radioactive Treatments

WASHINGTON, D.C.—The Armed Forces Institute of Pathology, with the approval of the division of biology and medicine of the U.S. Atomic Energy Commission, has compiled a list of precautions to be used in autopsy and embalming procedures following the administration of radioisotopes.

The radioisotope laboratory should supply the record office of hospitals with an up-to-date list of all patients who have received radioisotopes, the instructions state. Names of all deceased persons should be checked against this list by the record office personnel. If the deceased has ever received isotopes, the individual in charge of the laboratory should be promptly notified.

The instructions continue:

"If the deceased has received a therapeutic dose of an isotope within two months the radiac survey officer should monitor the body before autopsy or release to a mortician. If an autopsy is to be performed, the record office should inform the pathologist who is to perform the autopsy that radioisotopes have been given. The pathologist should secure from the radiac survey officer a report of the amount of radioactivity and copies should be attached to the autopsy protocol and the clinical chart."

The precautions to be taken, the instructions state, will depend on the level of radioactivity found by the radiac survey officer. They include:

1. In cases where the level is less than one-half milliroentgen/hour (mr/hr) no special precautions are necessary at any time.

2. In cases where the level is from ½ to 6 mr/hr the only precaution necessary in handling the body would be the wearing of rubber gloves, which should be washed with soap and water before they are removed from the hands.

3. In cases where the level is more than 6 mr/hr further percautions are necessary in order that the maximum permissible exposure of 0.3 r per week shall not be exceeded. The additional precautions in such cases should be: (1) the wearing of a lead apron and a dosimeter; (2) thorough cleansing with soap and water or detergent of tables and other surfaces on which blood or other body fluids have been spilled, and (3) the avoidance of eating and smoking while wearing the rubber gloves.

In all cases of positive radioactivity, described in 2 and 3, every effort should be made to confine body fluids that are removed during the course of the postmortem procedures to special vessels, to pour them directly into the drain, and to flush the drain copiously, with water, the instructions read.

The instructions further state:

"In cases where it is desired that organs or body fluids be retained for further study, they should be kept in special containers and suitably labeled. As the radioactivity decreases rather rapidly, these materials could be retained until their level of radioactivity has fallen below the danger level as determined by radiac survey; otherwise the precautions as noted herein should be carried out.

"The mortician should be given instructions similar to those given to the pathologist, the nature of which

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NEWS...

will depend upon the degree of radioactivity remaining at the time of delivery of the body to the mortician."

Iowa Association Helps Public Hospital Workers

DES MOINES, IOWA.—Largely through the efforts of the Iowa State Hospital Association, employes of public institutions in the state expect relief, under legislation now proposed, from inadequate protection under the Public Employes Retirement Act.

In an active campaign conducted by the association, it was reported here last month, inadequacies of the present statute were brought to the attention of the employes themselves and public officials, with the result that remedial legislation is to be introduced in the state legislature, providing for inclusion of public employes in the Federal Old Age and Survivors Insurance System.

Under the present system, Marion B. Dennis, executive secretary of the association, reported, "Tax supported hospitals found themselves unable to recruit and retain competent personnel. Employes of these agencies contribute 4 per cent of their earnings up to $3000, but when they move from a tax supported agency to industry, business or a voluntary hospital, they lose these contributions. The federal tax, on the other hand, is only 1½ per cent, and employes can move freely from one hospital or place of business to another within the state. Thus nurses and technicians were reluctant to work in the 58 tax supported hospitals of the state.

"The voluntary hospitals were in sympathy with the plight of their colleagues, and the association therefore undertook a survey to show the injustices and inequities of the present law."

In its survey and the educational campaign that followed, the association cooperated with librarians, teachers and union groups faced with the same problem in public agencies.

"The entire project has aided communities to understand the personnel problems of the hospitals and has created much warmth of feeling for the work they are doing," Miss Dennis concluded. "Hospitals have become, in the minds of the citizens, agencies as much interested in helping the people in health as in sickness."

NEWS...

Dr. Steelman Praises Work of Health Resources Advisory Committee

WASHINGTON, D.C. — No other phase of mobilization has had more effective planning and coordination than health has had, Dr. John R. Steelman, acting director, Office of Defense Mobilization, stated here in a summary report of the Health Resources Advisory Committee, Office of Defense Mobilization, covering the period August 1950 to August 1952.

The Health Resources Advisory Committee was established in August 1950, shortly after the outbreak in Korea, at the suggestion of the President by the chairman of the National Security Resources Board to advise that body on matters concerned with the health resources of the nation as they relate to national defense. The committee was later designated by the President to serve as the national advisory committee to the Selective Service System on the "doctor draft" law. In April 1952 it and its supporting staff were transferred to the Office of Defense Mobilization.

The key to achievements of the committee, Dr. Steelman declared, has been the close and effective working relationships it has developed not only with government agencies but with the national professional organizations, voluntary agencies, educational institutions, and other groups concerned with health.

He said, "The committee has enjoyed the confidence of all the groups with which it has worked as its doors have always been open to them to discuss any problems of mutual interest. Those professional and civilian organizations concerned with health problems have played a major rôle in the determination of the national policies concerning health resources that affect them."

Dr. Steelman called particular attention to the work of the committee in reviewing and advising the Secretary of Defense on the effect of the projected over-all requirements of the armed services for health personnel upon the civilian health economy of the nation. This close cooperation with the Department of Defense, he stated, has enhanced the nation's ability to meet both the current and future health needs of our civilian population and of the armed forces without endangering civilian health services.

Dr. Steelman also congratulated both the Health Resources Advisory Committee and its state advisory committees on the methods they have developed for determining the civilian essentiality of individual physicians and dentists who are liable for military service. Through the efforts of these state and local advisory committees, he declared, the Health Resources Advisory Committee in its dual responsibility as the national advisory committee to the Selective Service System has assured our local communities they would not be deprived of essential local health services and that vital research or teaching programs would not be disrupted. He credited the excellent cooperation of the medical, dental and health professions to the success of this program.

Other particularly significant achievements of the committee, he stated, have

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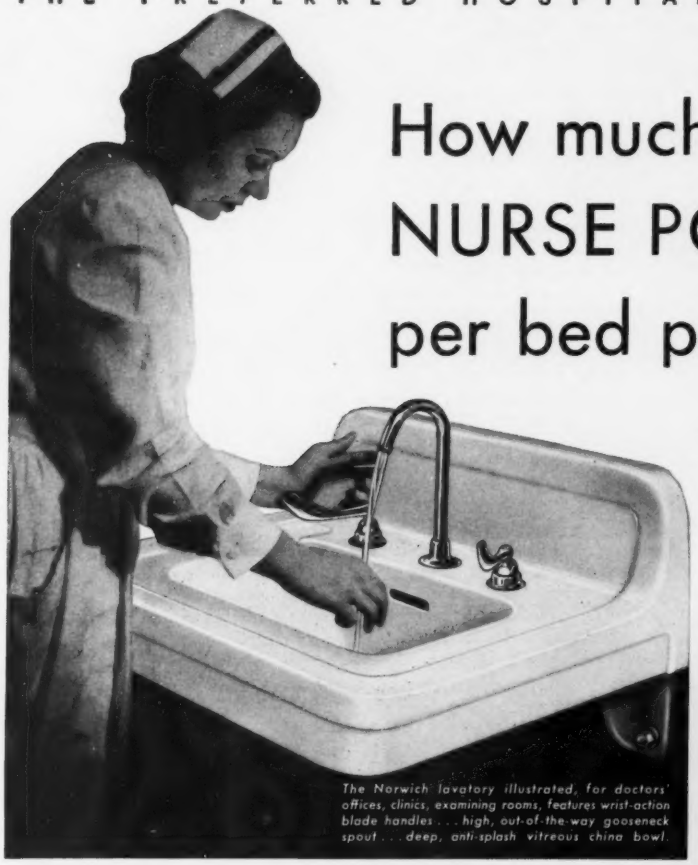

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been (1) the development of a single national blood program that can serve the needs of the Department of Defense, Federal Civil Defense Administration, and American National Red Cross and at the same time assure the normal day-to-day needs of the civilian population; (2) the analyzing and coordinating of information on better utilization of hospital personnel in order to alleviate the critical shortage of nurses by the newly formed subcommittee on hospital services; (3) its work with the Federal Civil Defense Administration in post-disaster planning; (4) its activities in industrial health, and (5) its many surveys, inventories and analyses of the nation's health resources.

Dr. Steelman stated that continuing effort in these and other areas will be necessary as long as the mobilization effort lasts and that he is in complete accord with the recommendation of the committee that "it is vital that somewhere in the federal government, at a sufficiently high organizational level to make its work effective, there must be a coordinating body in the health field if full utilization for both civilian and military needs is to be made of the health potentials of our nation." The achievements of the committee, he said, show the importance of this recommendation.

COMMITTEE MEMBERS

The membership of the Health Resources Advisory Committee consists of: Dr. Howard A. Rusk, professor and chairman of the department of physical medicine and rehabilitation, New York University, Bellevue Medical Center, New York City; Dr. Edwin L. Crosby, director, Joint Commission of Accreditation of Hospitals, Chicago; Dr. Harold S. Diehl, dean of medical sciences, University of Minnesota, Minneapolis; Dr. Alan Gregg, vice president, Rockefeller Foundation, New York City; Ruth Kuehn, R.N., dean of school of nursing, University of Pittsburgh, Pittsburgh; Dr. James C. Sargent, chairman, council on national emergency medical service, American Medical Association, Milwaukee; Dr. Leo J. Schoeny, member, special committee on national emergency dental service, American Dental Association, New Orleans, and Dr. W. P. Shepard, vice president, Metropolitan Life Insurance Company, San Francisco.

Iowans Seek Revision of Hill-Burton Program

DES MOINES, IOWA.—Because of operating difficulties encountered by many hospitals constructed under the Hill-Burton program in Iowa, trustees of the Iowa State Hospital Association have recommended careful study of the state hospital construction plan, looking toward revision of the plan in line with realistic understanding of hospital problems at the present time, Donald W. Cordes, association president and administrator of Iowa Methodist Hospital here, reported last month.

A resolution passed by the state hospital advisory council gave tentative approval to a revised construction program for 1952-53, subject to a qualifying resolution, it was reported. The resolution pointed out that total bed needs as outlined in the construction program "constitute the maximum number of beds which may be built with federal grants-in-aid and do not necessarily represent the accurate and

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exact hospital bed needs for the respective hospital or area."

In a statement elaborating on the resolution, the advisory council recommended that each community study its hospital bed needs by means of a thorough and detailed survey of local conditions affecting hospital utilization. "The program resulting from the findings from this survey and study should determine the number of hospital beds to be built, rather than attempting in every case to provide the total number of beds mathematically calculated by national ratios of bed needs," the council stated.

The state department of health concurred in the resolution and made it a part of the official revision of the Iowa hospital plan, Mr. Cordes reported.

"It was the consensus of the trustees of the state hospital association that projections of this hospital plan have serious adverse implications for future hospital construction within the state," Mr. Cordes said in a letter transmitting a copy of the advisory council's resolution to the U.S. Public Health Service in Washington.

"Since many of the hospitals already constructed under Hill-Burton funds are having serious difficulties in maintaining an adequate census to support operations, the member hospitals of our state association are strong in their conviction that revision of the hospital construction plan with attendant priority scales should be most carefully studied. Our member hospitals are much concerned about future hospital construction in our state, and we stand ready at any time to meet with the hospital division of our state health department, representatives of the Public Health Service, and any other person who may be helpful in devising a realistic plan of future construction that will reflect the best thinking of all concerned with the problem."

Mary K. Dawson Given V.A. Service Medal

WASHINGTON, D.C.—The Veterans Administration's highest award — the Exceptional Service Medal—was presented to Mary K. Dawson, chief of the nursing service at the Bedford Veterans Administration Hospital, Bedford, Mass., at a special ceremony recently.

Miss Dawson retired August 31 after 32 years of government service, 26 years of which were spent as chief nurse in veterans' neuropsychiatric hospitals. The award was made in recognition of her "unselfish service and outstanding leadership" which will "continue to have a marked influence on the entire V.A. nursing service." She is one of three V.A. employes to receive the medal since the inception of the award the first of this year, and the first woman to whom it has been given.

Nurse Killed in Hold-Up

CHICAGO.—M. Elizabeth Brett, chief surgical nurse at Wesley Memorial Hospital here, was slain September 14. The nurse was the victim of an apparent hold-up attempt as she and Dr. Ira J. Tresley, a Chicago physician, sat in the latter's car, which was parked in front of the nurses' home, near the hospital. Miss Brett had been scheduled to teach nursing at St. Francis Hospital, Evanston, within a few weeks.

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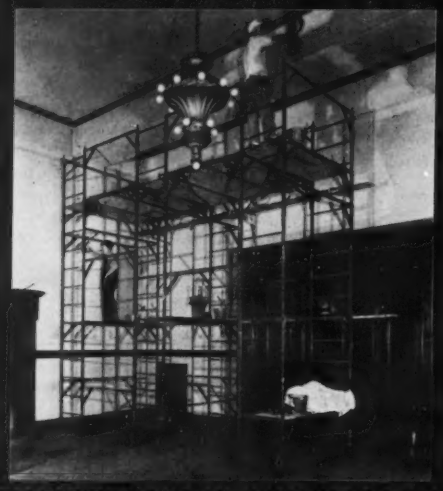

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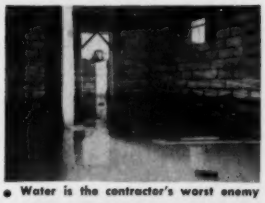

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Small Hospital Slant Is Program Need

ST. LOUIS.—Analysis of the registration at the Mid-West Hospital Association convention at Kansas City last April revealed that of 1856 persons registered 232 were administrators of hospitals in the seven states of the midwest district, a report to the association from H. J. Mohler, president-elect, indicated last month.

The report added there were 37 business managers attending the convention, and 811 "other hospital representatives"—a total of 1080 in the hospital group.

Others making up the total registration included exhibitors, representatives, visitors, public health officials, and others from related fields.

Largest state attendance was from Missouri, with 527 hospital representatives. Kansas had 350 representatives at the convention; other midwest states sent much smaller groups. States from other regions represented at the meeting included Iowa, Kentucky, Michigan, New York, New Mexico and Texas.

The report also analyzed hospitals in the seven states of the midwest region by size, indicating that in these states there are 492 hospitals with 100 beds and fewer, and only 130 hospitals with more than 100 beds not owned by the federal or state government. "This survey clearly shows it is necessary that more and more attention be given to the smaller hospitals," Mr. Mohler stated. "I am sure that few from the smaller hospitals can apply suggestions made by a speaker from a 250 or 500 bed hospital to their own needs."

The report also indicated that the number of government hospitals in the area is increasing. "The fact that there are 51 federal hospitals with 22,349 beds presents a serious problem for the nonprofit hospital in the various communities," the report stated, "in view of the fact that salaries, vacations, sick allowances and working conditions in the government hospitals are generally much more favorable and deficits are no great worry to the administrator—and the same applies to collections."

Suggesting what the report meant in terms of the midwest program, Mr. Mohler said: "It is evident we must interest the smaller hospitals in various ways. We must have more speakers who are familiar with their problems; speakers from large hospitals, without small hospital experience, do not speak the language suitable for the needs of the smaller hospital group.

"We must also provide for part of the income of the midwest to be used on smaller hospitals, through their own state associations," Mr. Mohler concluded.

New York May Curtail Large Building Program

NEW YORK.—The budget director has warned Mayor Impellitteri that New York City must move slowly in completing its $150,000,000 hospital building program.

Three reasons are given by the budget director: (1) labor and materials costs have shot up since 1949 when the hospital building program was adopted; (2) the unusually high cost of operating hospitals, and (3) the difficulty of recruiting doctors and nurses and the highly competitive mar-

ket for other types of hospital employes.

Abraham D. Beame has urged the mayor that the city not commit itself to any new hospital construction beyond that provided in the 1952 budget. Mr. Beame asserts that the city already faces the prospect of having to provide an additional $64,068,088, within the debt limit, over a three-year period to complete construction of hospitals estimated three years ago to cost only $150,000,000.

Proposed hospital projects that might be held up if Mr. Beame's recommendations are accepted include the proposed $10,000,000 Bedford-Stuyvesant Hospital in Brooklyn, the Kings County Laboratory Building and the proposed extensive modernization of Gouveneur Hospital on the lower East Side of Manhattan.

Hospital leaders in the city were much upset over the budget director's statement and told the mayor that the city must decide once and for all whether it wants to "lessen overcrowding or be satisfied with cramped and outmoded facilities."

The proposed limitation program would curtail alteration plans at Lincoln, Fordham, Greenpoint, Kings County, Sea View, Neponsit Beach and Sydenham Hospital, as well as at the Municipal Sanatorium at Otisville, N.Y. Improvements at these institutions include modernization of operating rooms, maternity services, utility space, outpatient units, and laboratory and x-ray departments. It might also affect the proposed 200 bed addition to Harlem Hospital, the most overcrowded institution in New York's municipal hospital system. Harlem now has an average daily census of 1000 patients and a bed capacity of 705.

In all fairness, Department of Hospitals officials stressed, it should be pointed out that there is more hospital construction going on now than ever before. Recently completed structures, built at a cost of $45,630,000, include the Francis Delafield, James Ewing, Bird S. Coler and the Kings County Tuberculosis Hospitals; the College Point Outpatient Building and the laundry-garage on Welfare Island.

The facilities in construction or on which construction is about to begin —the total cost of which will come to $127,064,000—include the Bronx Municipal Hospital Center, Bellevue Hospital's nurses school and residence, the East Harlem General Hospital, the Queens General Hospital Center addition, the Elmhurst General Hospital in Queens and the Coney Island Hospital in Brooklyn.

Dedicate Medical Center Building at Mary Fletcher

BURLINGTON, VT.—About 900 persons attended the dedication ceremonies here September 4 of the new $2,600,000 medical center building of the Mary Fletcher Hospital.

Dedication of the new building came just 75 years after construction of the first hospital building, which was made possible through the benevolence of Mary Fletcher. The hospital is the oldest and largest in the state of Vermont.

Following the ceremonies, the new building was opened to the public for inspection. The open house, which continued for four days, attracted approximately 10,000 visitors.

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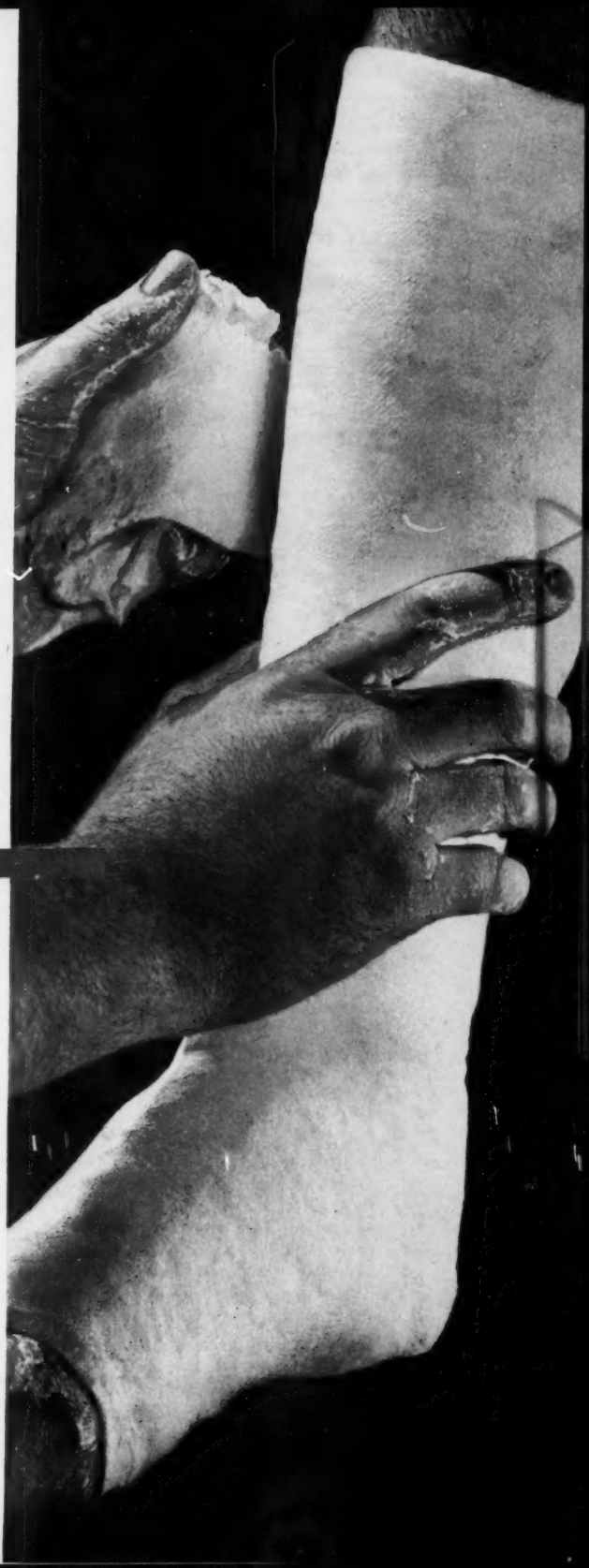

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ABOUT PEOPLE

(*Continued From Page 92*)

dency at Herrick Memorial Hospital, Berkeley, Calif., received his master's degree in hospital administration from Northwestern University. He served 19 months in the navy hospital corps.

Henry J. Whyte has been named administrator of Community Hospital, Wilmington, N.C., succeeding **Charles Wilson Jr.** His former position was as administrative assistant at Freedmen's Hospital, Washington, D.C. In June 1951, Mr. Whyte received his master's degree in hospital administration from Columbia University. He is a member of the American College of Hospital Administrators.

John Eller, formerly purchasing agent at Bethany Hospital, Chicago, succeeded **B. W. Selin** as administrator of the hospital on July 1.

Manuel Cohen has been appointed assistant director of Montefiore Hospital, the Bronx, N.Y. Mr. Cohen's postgraduate degree in public health and hospital administration was obtained at Yale University's school of medicine, in its department of public health. He served his administrative residency at Montefiore.

Dr. John W. Fristoe Jr. has succeeded **Dr. H. F. Magee** as director of the Mississippi State Charity Hospital, Jackson. Dr. Fristoe has been acting director since Dr. Magee's resignation last April. Previously he served for one year as resident specialist in obstetrics and gynecology for the Mississippi State Board of Health in Jackson.

Gene S. Bakke, administrator of Grand Forks Deaconess Hospital, Grand Forks, N.D., since 1950, has resigned. His successor is **Leonard H. Egstrom,** formerly general secretary of the Young Men's Christian Association in Grand Forks.

Mrs. Stafford Brooke, R.N., a former superintendent of Hamilton Memorial Hospital, Dalton, Ga., has been appointed to resume the position, succeeding **Marjorie Nicholson.** Mrs. Brooke first became superintendent of the hospital in 1942.

Lloyd G. Jenson, formerly administrator of the Saunders County Hospital, Wahoo, Neb., is the new superintendent of Childrens Memorial Hospital, Omaha, Neb., succeeding **Phyllis Levens.** Mr. Jenson, who received his master's degree in hospital administration from Washington University, served his administrative residency at Ancker Hospital, St. Paul. At present Mr. Jenson is a member of a three-man committee for revision of the regulations of the Nebraska State Health Department.

Rowland M. Dearing has succeeded **John R. Purcell** as superintendent of Flagler Hospital, St. Augustine, Fla. For the last several years Mr. Dearing has been superintendent of Fostoria City Hospital, Fostoria, Ohio. Previously, he served as superintendent of Corry Hospital, Corry, Pa., and as administrator at the War Relocation Hospital, Heart Mountain, Wyo.

Sister Mathilde is the new administrator of St. Vincent's Hospital, Kansas City, Mo., succeeding **Sister Agnes,** who is now associated with St. Vincent's Infant Home, Milwaukee.

James W. Brown Jr., formerly administrative aide and purchasing agent at Grady Memorial Hospital, Atlanta, Ga., has been named an assistant superintendent of the hospital.

Sister M. Dolorata, O.S.F., has become administrator of St. Joseph's Hospital, Philadelphia, exchanging

positions with **Sister M. St. Robert, O.S.F.,** who assumes similar duties at St. Joseph's Hospital, Reading, Pa.

Harry A. Blythe has been named director of city hospitals of Winston-Salem, N.C. Mr. Blythe was originally appointed administrator of City Memorial Hospital, Winston-Salem, but was later given the new post. In this capacity Mr. Blythe not only is director of City Memorial but also heads the Kate Bitting Reynolds Memorial Hospital. He formerly was assistant superintendent of the University of Chicago Clinics. Mr. Blythe, who received his master's degree in hospital administration from Northwestern University, is a member of the American Hospital Association, the North Carolina Hospital Association, and the American College of Hospital Administrators.

Herman R. Goldberg is the newly appointed administrative assistant to the executive director of the Albert Einstein Medical Center, Philadelphia. **Robert M. Sigmond,** assistant director of the northern division of the center, has been granted a leave of absence to become director of fiscal studies for the national Commission on Financing Hospital Care. The commission's headquarters are in Chicago.

William S. Marshall has succeeded **R. W. Airey Jr.** as administrator of Pioneer Memorial Hospital, Prineville, Ore. Mr. Marshall previously was associated with the Caterpillar Tractor Company, Peoria, Ill.

Sister Reine has succeeded **Sister Rose of the Precious Blood** as superintendent of Sacred Heart Hospital, Medford, Ore. Sister Rose, who has supervised the hospital for the last two years, has been transferred to St. Elizabeth's Hospital, Yakima, Wash.

Robert Wilkins has been named acting administrator of Community Hospital, Inc., at Medford, Ore.

Thelma Bergstresser, R.N., is the new superintendent of the Brodstone Memorial Hospital, Superior, Neb., succeeding **Marie Hartell.**

Opal Johnson, R.N., has been appointed superintendent of the new Franklin County Memorial Hospital, Omaha, Neb.

Arthur G. Burns has been appointed supervisor of the hospital division of the Florida State Improvement Commission with headquarters in Tallahassee. Mr. Burns was formerly administrator of Lawrence General Hospital, Lawrence, Mass.

Department Heads

Lt. Col. Harry A. Horstman Jr. has been named chief of the outpatient service at Walter Reed Army Hospital, Washington, D.C. Colonel Horstman, a graduate of the Georgetown University School of Medicine, for the last three years has been assistant chief of the medical service at Rodriquez Army Hospital, San Juan, Puerto Rico. He is an associate member of the District of Columbia Medical Society and an associate in the American College of Physicians. He was qualified by the American Board of Internal Medicine in 1950.

Josephine Durham assumed her new duties August 1 as director of nurses at East End Memorial Hospital, Birmingham, Ala. She succeeded **Mrs. Ferrell Pearce,** who resigned July 1.

Henrietta R. Hennik is the new director of nursing and principal of the school of nursing at Faulkner Hospital, Jamaica Plain, Mass., succeeding **S. Daphne Corbett,** who resigned in order to do further graduate study. Miss Hennik formerly was assistant

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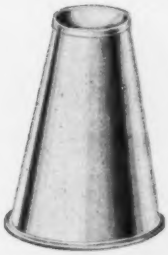

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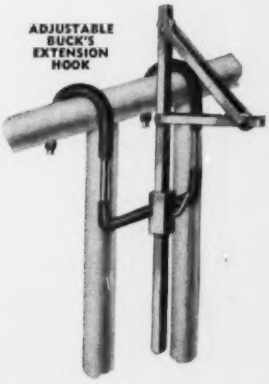

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director of nursing at Peter Bent Brigham Hospital, Boston.

Dr. Russell B. Street Jr., formerly assistant pathologist at the Massachusetts Memorial Hospital, Boston, is now pathologist and head of the Quincy City Hospital laboratory at Quincy, Mass.

Mrs. Frances Haise, R.N., is now nursing service director at St. Joseph Hospital, Memphis, Tenn.

Oliver Bergevin is the newly appointed office manager of Good Samaritan Hospital, Portland, Ore. Formerly a corporation accountant, Mr. Bergevin also has served as a public accountant in Walla Walla, Wash.

Jane Ashby is the newly appointed administrative dietitian of Children's Memorial Hospital, Omaha, Neb., succeeding **Ellen Hesse.** Mrs. Ashby formerly was assistant dietitian.

Sister Mary Odolina, O.S.F., R.N., surgical supervisor for 17 years at Creighton Memorial St. Joseph's Hospital, Omaha, Neb., has been appointed to a similar post at St. Elizabeth Hospital, Lincoln, Neb. In her new work she will organize the operative service of the new surgical pavilion to be housed in the hospital's new addition. Succeeding Sister Odolina at the Omaha institution is **Sister Mary Ann Frances, O.S.F., R.N.,** who received her master's degree in nursing education in June at St. Louis University.

Miscellaneous

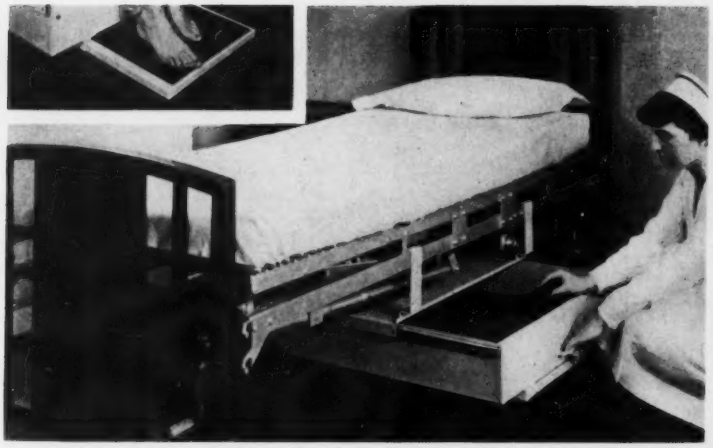
Dr. Norman H. Topping has been appointed vice president of the University of Pennsylvania in charge of medical affairs. His appointment will be effective November 1. Dr. Topping is now associate director of the National Institutes of Health at Bethesda, Md., research branch of the Public Health Service, Federal Security Agency, and an assistant surgeon general. As medical vice president, Dr. Topping will administer the university's entire medical program, which includes six schools and the related hospitals and laboratories. A past president of the American Society of Tropical Medicine, Dr. Topping is a member of the Association of American Physicians, American Public Health Association, American Medical Association, American Academy of Tropical Medicine, American Epidemiological Society, and the Society of Experimental Biology and Medicine. Besides the Typhus Commission Medal, Dr. Topping has received the A.S.T.M.'s Eli Lilly Bailey K. Ashford Award and the award of the Washington Academy of Science.

Deaths

Mrs. Barnett Davis, who organized the Ladies' Hospital Aid Society in 1898, which led to the founding of Montefiore Hospital, Pittsburgh, 10 years later, died August 16. She served as president of the society for 20 years. She also had served as president of the Jewish Home for Babies and Children in Pittsburgh.

Dr. Alfred K. Haywood, O.B.E., superintendent of the Vancouver General Hospital, Vancouver, B.C., for 17 years until his retirement in 1947, died recently. Before going to Vancouver he was superintendent of the Montreal General Hospital for 13 years. From 1914 to 1917 he was in the Canadian Army.

Dr. Haywood was the first person to receive, in 1949, the George Findlay Stephens Memorial Award, established in memory of the late **Dr. George F. Stephens,** former superintendent of the Royal Victoria Hospital, Montreal, Que., from the Canadian Hospital Council.



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Thirty-two manufacturers of products especially suited to your food service department are cataloged in the 29th Edition of Hospital Purchasing File. If your copy is on your desk, where it should be, thumb through this section and see the wide range of information, the ample illustrations, and detailed specifications on equipment for hospital kitchens. Next time you discuss feeding problems with your dietitian, open your copy of Hospital Purchasing File to Section B. Point out to her all the things she can find in this section. Be sure you yourself are familiar with the scope of this buying service. Be sure always to look first for product data in Section B and in the fifteen other sections as well, each keyed to a specific department of your hospital.

THESE MANUFACTURERS CAN HELP YOU. You will find their product information in Section B of the 29th Edition of HOSPITAL PURCHASING FILE:

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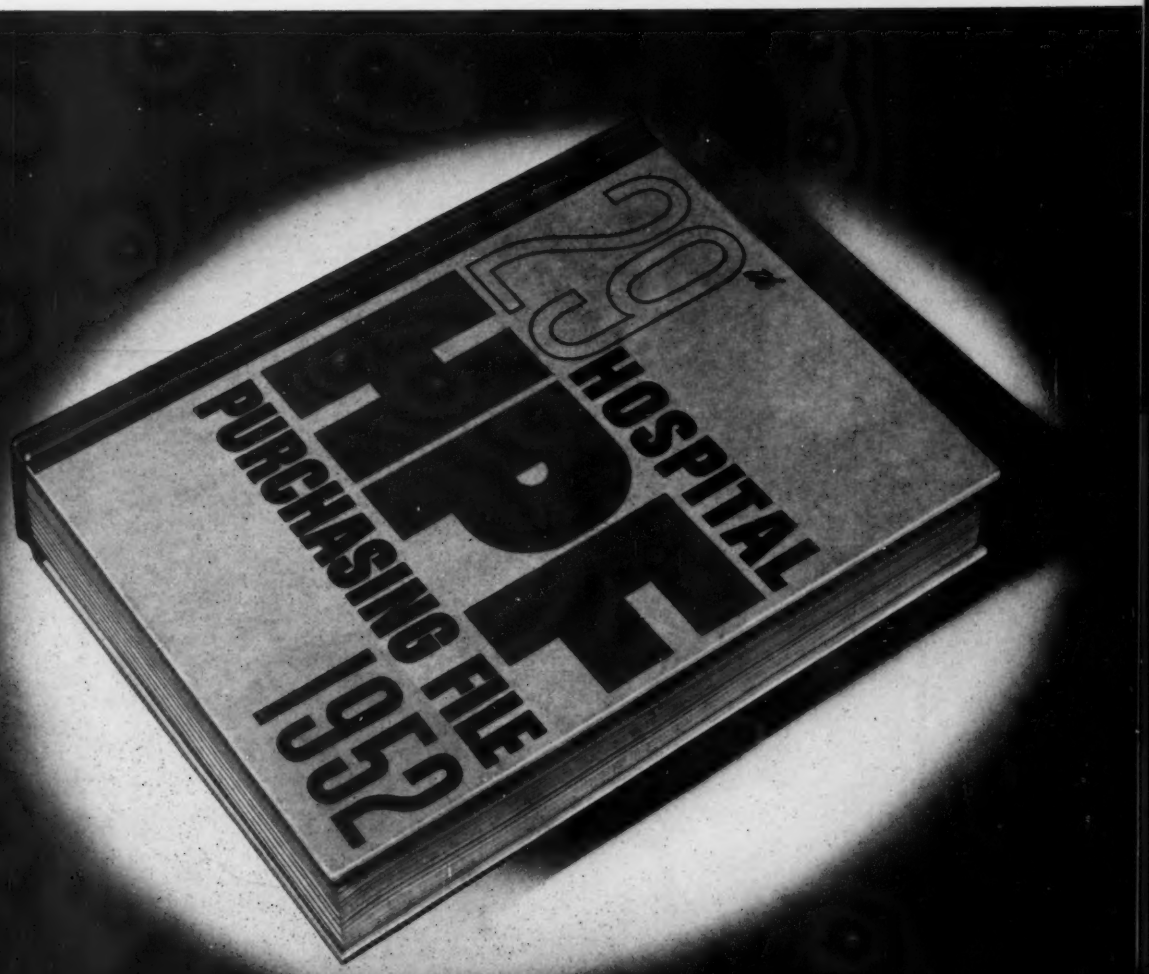

ESTABLISHED AS THE HOSPITAL YEAR BOOK IN 1919 BY THE MODERN HOSPITAL PUBLISHING CO. INC.

PURCHASING FILES, INC.

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COMING EVENTS

AMERICAN ACADEMY OF PEDIATRICS, Palmer House, Chicago, Oct. 20-23.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Shoreham Hotel, Washington, D.C., Oct. 13-17.

AMERICAN COLLEGE OF CLINIC ADMINISTRATORS, Chase Hotel, St. Louis, Dec. 6, 7.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Fellows' Seminar, University of Michigan, Ann Arbor, Dec. 5-8.

AMERICAN CANCER SOCIETY, New York City, Oct. 23.

AMERICAN DIETETIC ASSOCIATION, Municipal Auditorium, Minneapolis, Oct. 21-24.

AMERICAN PUBLIC HEALTH ASSOCIATION, Cleveland Hotel, Cleveland, Oct. 20-24.

CALIFORNIA HOSPITAL ASSOCIATION, Mar Monte Hotel, Santa Barbara, Nov. 6, 7.

COLORADO HOSPITAL ASSOCIATION, Cosmopolitan Hotel, Denver, Nov. 6, 7.

CONNECTICUT HOSPITAL ASSOCIATION, Auditorium, Southern New England Telephone Co., New Haven, Nov. 18.

ILLINOIS HOSPITAL ASSOCIATION, Abraham Lincoln Hotel, Springfield, Nov. 20, 21.

INSTITUTE FOR MEDICAL RECORD LIBRARY PERSONNEL, Radisson Hotel, Minneapolis, Nov. 10-14.

INSTITUTE ON ACCOUNTING, Knickerbocker Hotel, Chicago, Nov. 10-14.

INSTITUTE ON LAUNDRY, Sheraton Hotel, Detroit, Oct. 13-17.

INSTITUTE ON NURSING SERVICE, San Francisco, Oct. 13-17.

INSTITUTE ON PURCHASING, Sheraton Hotel, St. Louis, Nov. 10-14.

INSTITUTE ON HOUSEKEEPING, St. Charles Hotel, New Orleans, Dec. 1-5.

INSTITUTE ON NURSING SERVICE ADMINISTRATION, Knickerbocker Hotel, Chicago, Dec. 8-12.

KANSAS HOSPITAL ASSOCIATION, Town House, Kansas City, Nov. 6, 7.

MANITOBA HOSPITAL ASSOCIATION, Royal Alexandra Hotel, Winnipeg, Oct. 22-24.

MARYLAND - DISTRICT OF COLUMBIA - DELAWARE HOSPITAL ASSOCIATION, Hotel du Pont, Wilmington, Del., Nov. 10, 11.

MEDICAL LIBRARY ASSOCIATION, Midwest Regional Group, Indianapolis, Ind., Oct. 17, 18.

MICHIGAN HOSPITAL ASSOCIATION, Statler Hotel, Detroit, Nov. 16-18.

MISSISSIPPI HOSPITAL ASSOCIATION, Heidelberg Hotel, Jackson, Oct. 16, 17.

MISSOURI HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Nov. 20, 21.

NATIONAL SAFETY COUNCIL, Conrad Hilton Hotel, Chicago, Oct. 20-24.

NEBRASKA HOSPITAL ASSOCIATION, Pathfinder Hotel, Fremont, Nov. 13, 14.

OKLAHOMA STATE HOSPITAL ASSOCIATION, Skirvin Hotel, Oklahoma City, Nov. 6, 7.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 27-29.

OREGON ASSOCIATION OF HOSPITALS, Pilot Butte Inn, Bend, Oct. 20, 21.

RHODE ISLAND HOSPITAL ASSOCIATION, Miriam Hospital, Providence, Dec. 13.

SOUTH DAKOTA HOSPITAL ASSOCIATION, Alex Johnson Hotel, Rapid City, Oct. 6, 7.

VERMONT HOSPITAL ASSOCIATION, Pavilion Hotel, Montpelier, Oct. 29, 30.

WASHINGTON HOSPITAL ASSOCIATION, Cascadian Hotel, Wenatchee, Oct. 22, 23.

1953

AMERICAN HOSPITAL ASSOCIATION, Midyear Conference, Drake Hotel, Chicago, Feb. 6, 7.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Palmer House, Chicago, Feb. 10-13.

ARIZONA HOSPITAL ASSOCIATION, Adams Hotel, Phoenix, Feb. 12-14.

MASSACHUSETTS HOSPITAL ASSOCIATION, Sheraton Plaza Hotel, Boston, Jan. 20.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, May 20-22.

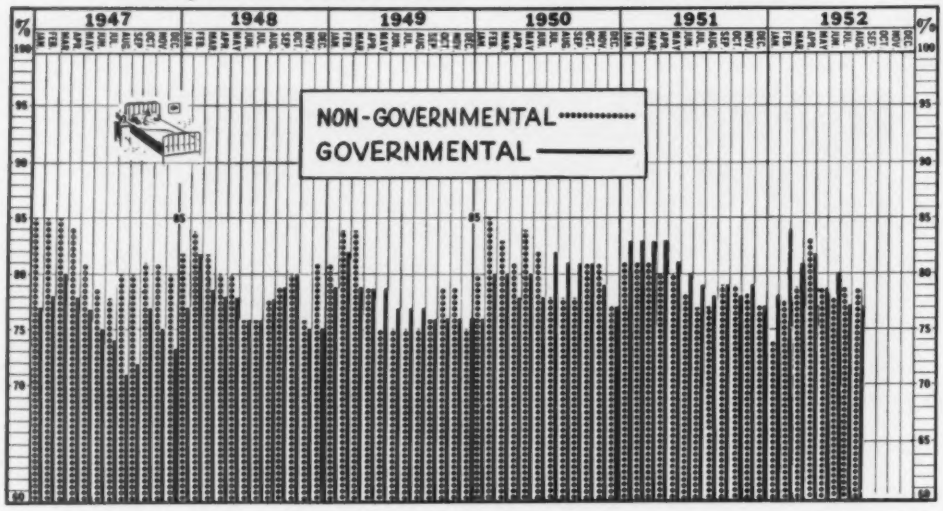
NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Palmer House, Chicago, Feb. 11, 12.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 20-22.

OHIO HOSPITAL ASSOCIATION, Netherland Plaza Hotel, Cincinnati, April 6-9.

SOUTHEASTERN HOSPITAL CONFERENCE, Jung Hotel, New Orleans, April 8-10.

Hospital Construction Totals $67,642,521

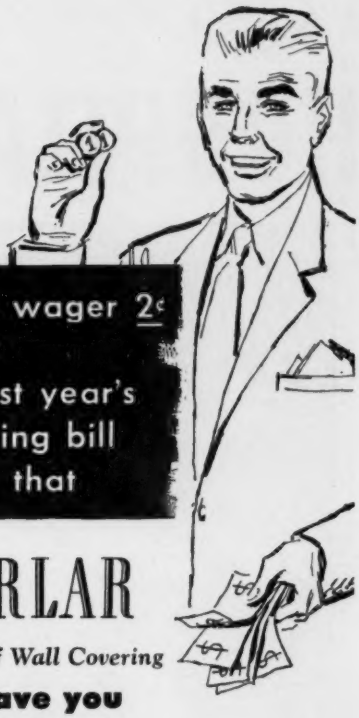


Voluntary hospitals have reported 78.9 per cent of occupancy for August 1952, which is slightly below the figure for July but an increase over reports for the same hospitals in August 1951.

Occupancy of governmental hospitals reporting to the Occupancy Chart was 77.4 per cent of capacity—approximately the same as last month, but a decline from the same month last year.

For the month ending September 8, hospital construction totaled $67,642,521. This brings construction for the year to $460,048,632, compared to $656,807,018 for the same period last year. Of the projects reported this month, 30 were new hospitals.

WILL you wager 2¢ against your last year's decorating bill that



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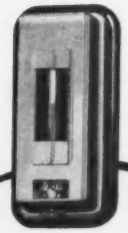

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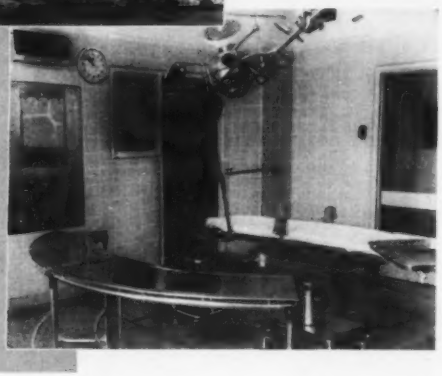

Man must rest but the mechanical "brains," which man has developed, work with precision . . . and with no time off. Johnson temperature control systems serve automatically, every minute of each hour.

At the St. John Hospital, as in most American hospitals, the small, busy thermostats on the wall are important, indeed, to the hospital's health service.

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ANESTHETIST—20 years experience; member A.A.N.A.,; available November 1; preferably new hospital; would like full maintenance, living in. MW 78, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIAN—Qualified; experienced in all phases of dietary department; desires position in hospital employing only one dietitian; full maintenance preferred. MW 77, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR—Personnel; lay; university trained in personnel field; early 30's; 4 years experience in non-profit hospital as well as in private industry. MW 80, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

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PALMOLIVE BUILDING CHICAGO

ADMINISTRATOR—Graduate nurse; B.S., Nursing; M.B.A., Hospital Administration; three years, director of nursing, university hospital; five years, assistant administrator, 450-bed hospital.

ADMINISTRATOR—Lay; B.Ph., Business Administration; M.S., Hospital Administration; administrative internship and four years, assistant administrator, university hospital; three years, administrator, 175-bed hospital.

ADMINISTRATOR—Medical; M.B.A. cum laude, Hospital Administration; five years, associate medical director, large teaching hospital; six years, director, voluntary general hospital, 300 beds; FACHA.

ASSISTANT ADMINISTRATOR—Master's Degree, Hospital Administration; recently completed administrative internship, large teaching hospital.

COMPTROLLER—B.S., Business Administration; four years' experience public accounting; seven years, supervisor, accounting department, 400-bed hospital.

PERSONNEL DIRECTOR—A.B. Degree; four years, personnel director, 300-bed general hospital.

MEDICAL BUREAU—*Continued*

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PATHOLOGIST—Diplomate, Pathologic Anatomy, Clinical Pathology; trained at university medical center; two years assistant professor of pathology, university medical center; six years, director of pathology, 375-bed general hospital.

RADIOLOGIST—Diplomate; Fellow, American College of Radiology; seven years, director, radiology, 300-bed hospital; now associated with radiological group; prefers directorship, hospital department.

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ADMINISTRATOR—Lay; one of country's outstanding men; very active national hospital affairs; past ten years, administrator, large teaching hospital; member, ACHA.

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ANESTHESIOLOGIST—Past three years, associate professor, anesthesiology, university medical school and chief, 800-bed general hospital; prefers private practice of anesthesiology in hospital.

BUSINESS MANAGER—Hospital or clinic; B.A., M.A., Business Administration; Ph. D.; eight years, business administrator, state university; six years, associate professor, business administration, important university and college; now desires to return to administrative hospital field; outstanding man.

COMPTROLLER—C.P.A.; past ten years, audits, 400-bed general voluntary hospital; same period, consultant, Blue Cross and all affiliated hospitals.

PERSONNEL DIRECTOR—B.S., Business Administration; past two years, personnel manager, 300-bed voluntary general hospital; late twenties.

(Continued on page 206)

WOODWARD—*Continued*

PATHOLOGIST—Diplomate, Pathologic Anatomy, Clinical Pathology; past seven years, director of laboratories, university hospital; and two years, faculty member, university medical school; any locality.

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Miss Elsie Dey, Director

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ADMINISTRATOR—M.H.A. Degree, 1947; graduate, midwestern university; 2 years internship, large Minnesota hospital; 3 years, administrator, church hospital, Kansas; desires change.

ASSISTANT ADMINISTRATOR—B.S. Degree, Business Administration; courses in accounting and law; 5 years banking experience; 3 years, assistant controller, large eastern hospital.

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HOUSEKEEPER—Thoroughly experienced; last position 7 years, 300-bed hospital; available.

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ANESTHETIST—For fully approved 80-bed general hospital in Pacific Northwest; 40-hour week; salary open. MO 81, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—For 331-bed general hospital; good working conditions, interested staff, salary $350 per month with maintenance. Write to Frank C. Haythorn, Superintendent, Greenville General Hospital, Greenville, South Carolina.

ANESTHETIST—110-bed hospital; work light; live in or out; salary $400 plus bonus and percentage on work. Mrs. Probandt, Superintendent, Belmont Hospital,, 4058 West Melrose Street, Chicago, Illinois. Pensacola 6-7000.

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ANESTHETIST—For 160-bed hospital; approved general hospital; with or without maintenance; salary open. Apply, Maryview Hospital, Portsmouth, Virginia.

ANESTHETIST—Excellent opportunity; 102-bed general hospital. Write or phone, Administrator, Northeastern Hospital, Philadelphia 34, Pennsylvania.

ANESTHETIST — Nurse; A.A.N.A.; five-day week; on call every fourth night, but need not stay at hospital; $350 per month plus one meal per working day; physician anesthetist in charge of department. Write to Carl C. Rasche, Administrator, Deaconess Hospital, 6150 Oakland Avenue, St. Louis 10, Missouri.

ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; salary dependent upon experience. Write, wire or call collect, S. K. Hummel, Administrator, Columbia Hospital, 3321 North Maryland Avenue, Milwaukee, Wisconsin.

ANESTHETIST—Nurse; 86-bed hospital; salary open; No. O.B. calls; liberal employee benefits. Apply, Superintendent, Group Health Hospital, 201 16th Avenue North, Seattle 2, Washington.

ANESTHETIST—Nurse; 600-bed approved general hospital; liberal personnel policy; salary dependent upon experience. Apply, Administrator, Good Samaritan Hospital, Cincinnati 29, Ohio.

ANESTHETIST—Nurse; 240-bed general hospital; excellent working conditions and good personnel policies; salary dependent upon experience. Apply, Administrator, Mercy Hospital, 144 State Street, Portland 3, Maine.

ANESTHETIST—Registered nurse; new McLaren General Hospital staff; 243 beds; salary open; social security and liberal employee benefits. Apply, McLaren General Hospital, 401 Ballenger Highway, Flint 4, Michigan.

ANESTHETISTS—Nurse; two urgently needed; modern, well equipped, 100-bed hospital, employing only graduate staff; attractive location within forty minutes of San Francisco; 5-day week; excellent salary; maintenance available. Administrator, Alameda Hospital, Alameda, California.

ANESTHETISTS—Nurse; for 150-bed community hospital; four nurses, full time M.D., all agents and techniques; good opportunity for advanced training; full maintenance and one month's vacation; two and one-half hours from Boston and New York. Write, G. J. Carroll, M.D., William W. Backus Hospital, Norwich, Connecticut.

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ANESTHETISTS—Nurse; two; for 125-bed general hospital; salary open; full maintenance. Apply to Superintendent, Maine Eye and Ear Infirmary, Portland, Maine.

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DIETITIAN—For 100-bed hospital; salary depends on experience and qualifications. For particulars apply, Superintendent, Soldiers' Memorial Hospital, Campbellton, New Brunswick, Canada.

DIETITIAN—100-bed state tuberculosis sanatorium; $275 per month; complete maintenance; supervision of 20 kitchen employees. Apply, Superintendent, State Sanatorium, Sanator, South Dakota.

DIETITIAN—Wanted immediately for 150-bed hospital; graduate staff; modern department; central tray service; salary commensurate with experience. Apply, Superintendent, St. Joseph's Hospital, Sarnia, Ontario, Canada.

(Continued on page 208)

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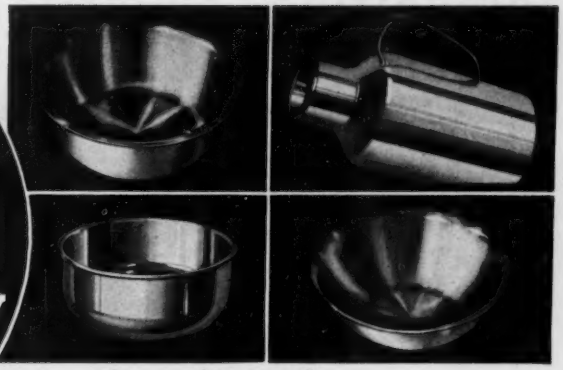

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POSITIONS OPEN

DIETITIAN—For 160-bed hospital; approved general hospital; with or without maintenance; salary open. Apply, Maryview Hospital, Portsmouth, Virginia.

DIETITIAN—Registered; for 200-bed modern teaching hospital; 40-hour week; good salary. Apply, Box 840, Battle Creek, Michigan.

DIETITIAN—For state hospital; salary depends on experience and qualifications. Apply, Superintendent, State Hospital, Jamestown, North Dakota.

DIETITIAN—Assistant; immediate opening, 225-bed hospital. Apply, William L. Mallory, Administrator, Genesee County Tuberculosis Hospital, Flint, Michigan.

DIETITIAN—Fully qualified to assist senior dietitian; 300-bed general hospital; good salary and working conditions in modernised kitchen. Apply, giving details of qualifications and experience to: Superintendent, Metropolitan General Hospital, Windsor, Ontario, Canada.

DIETITIANS—Therapeutic and administrative; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $245 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIANS—A.D.A., therapeutic and administrative assistants for new 212-bed general hospital located in residential area; ultra-modern, well equipped kitchen and diet kitchen; 40-hour week; good personnel policies. Apply, Supervising Dietitian, Sinai Hospital, 6741 West Outer Drive, Detroit, Michigan.

DIRECTOR—Educational; B.S. in Nursing Education required; experience preferred; class admitted annually in September; sciences taught at junior college; 40-hour week; salary open; 370-bed, well equipped hospital; near Virginia beach. Write, Personnel Director, Norfolk General Hospital, Norfolk 7, Virginia.

DIRECTOR—NURSING. To take charge of nursing home, attractively located, 24 beds; operated by The Benjamin Rose Institute in conjunction with the Benjamin Rose Hospital, affiliated with Western Reserve University Medical School and university hospitals; attractive newly remodeled apartment available, offering complete privacy; salary open. The Benjamin Rose Institute, 1000 Rose Building, Cleveland 15, Ohio.

DIRECTOR OF NURSES—For 100-bed general hospital with school of nursing, November 1; degree and experience in nursing education necessary; salary open; excellent personnel policies; hospital located in southwestern part of Virginia; ideal climate. Apply, Administrator, Pulaski Hospital, Pulaski, Virginia.

(Continued on page 210)

DIRECTOR OF NURSING—Assistant; Bachelor's Degree; experience in nursing services and staffing; good salary depending upon qualifications. Apply to Director of Nursing, Columbia Memorial Hospital, Hudson, New York.

DIRECTOR OF NURSING DEPARTMENT—College degree required; 125-bed Methodist hospital expanding to 185 beds; construction in progress; 60 students in school of nursing; experience required in nursing supervision and nursing education; salary open, dependent on education and experience. Apply, Administrator, Grace Hospital, Hutchinson, Kansas.

DIRECTOR OF NURSING SERVICES—500-bed teaching hospital in ideal southern California location; salary $440-$545; merit system benefits. For detailed information, write to Orange County Personnel Department, 644 North Broadway, Santa Ana, California.

DIRECTORS—Recreational, both male and female recreational directors are desired at state hospital. Apply, Superintendent, State Hospital, Jamestown, North Dakota.

INSTRUCTOR—Clinical; to teach orthopedics and the communicable diseases; salary for degree and experience $3804 to $4164; retirement program and social security; 441-bed hospital in a beautiful 40-acre park; liberal personnel policies. Apply, Director of Nurses, Reading Hospital, Reading, Pennsylvania.

classified advertising

POSITIONS OPEN

INSTRUCTOR—Nursing arts; for 192-bed hospital, 70 students; immediate opening; new educational department under construction; salary open. Apply to Director of Nursing, House of the Good Samaritan, Watertown, New York.

INSTRUCTOR—Science; for 100-bed general hospital school of nursing; good working and living conditions; salary open, depending upon training and experience. Apply, Director of Nursing Science, Pulaski Hospital, Pulaski, Virginia.

LIBRARIAN—Medical record; for fully approved 80-bed general hospital in Pacific Northwest; 40-hour week; salary open. MO 82, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

LIBRARIAN—Medical records; for 200-bed general hospital with program of expansion; duties, to assist in establishing, and to later supervise the indexing and coding of diagnosis and systems of medical accounting; salary will depend on qualifications and experience. Please address enquiries to H. F. Garwood, Administrator, Greater Niagara General Hospital, Niagara Falls, Ontario, Canada.

LIBRARIAN—Medical records; applications from qualified medical records librarians are being sought for the post of chief medical records librarian in 240-bed general hospital. Further details upon writing: The Superintendent, St. Joseph's General Hospital, Port Arthur, Ontario, Canada.

LIBRARIANS—1500-bed west coast teaching hospital, with newly organized medical records department and staff of 36, invites applications for the following positions: Associate chief medical record librarian (new position); Senior medical record librarian; Medical record librarian (new position); all applicants must be registered. Address replies to MO 3, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

MEDICAL SECRETARY—For hospital in midwestern city of 200,000; hospital being enlarged to 270-bed capacity; qualifications: experienced in medical field, executive ability, keep medical records, originate medical reports, first class stenographer, pleasing personality, able to meet the public; duties are of a highly technical nature; at least two years of college preferred or the equivalent thereof; pleasant surroundings and excellent maintenance facilities if desired; salary commensurate with ability and experience. MO 4, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

(Continued on page 212)

MISCELLANEOUS—Superintendent of nurses and Assistant superintendent of nurses: state salary expected; Operating room supervisor: salary $220 gross; Science instructor: salary $220 gross; Arts instructor: $220 gross; General duty nurses: salary $180-195 gross depending on experience; 44-hour week; 2⅓ days holiday per month; half day on statutory holidays; 1½ days per month sick time cumulative to 30 days; charge of $30 per month for board and room; nurses working evening and night shifts to receive $5 per month over schedule. Apply to Mrs. M. Alexander, Acting Superintendent of Nurses, General Hospital, Medicine Hat, Alberta, Canada.

MISCELLANEOUS—Supervisor and Graduate nurse for 20-bed hospital; salary $250 per month, all meals and uniform laundry; wonderful climate, beautiful section of the country; near Yellowstone Park and Sun Valley. MO 95, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

MISCELLANEOUS—Graduate nurses for general staff duty, Operating room nurses, and Dietitian (A.D.A. desirable but not compulsory). MO 6, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSE—Registered; for general duty; meals while on duty and laundry of uniforms. Apply, Business Manager, Lockney General Hospital, Lockney, Texas.

NURSE—General floor supervisor for 34-bed hospital; salary open. Reed City Hospital, Reed City, Michigan.

classified advertising

POSITIONS OPEN

NURSE—General duty; small growing hospital; good pay, part maintenance; paid vacations; pleasant working conditions. Apply, Supervisor of Nurses, Hi-Plains Hospital, Hale Center, Texas.

NURSE—Graduate; for relief duty, 3-11 P.M., with medical and surgical patients in small 35-bed community hospital; salary $201.90 per month plus full maintenance and uniform laundry; 44-hour week; paid vacation, sick leave, and holiday time. Apply, Superintendent, Edgerton Memorial Hospital, Edgerton, Wisconsin.

NURSES—General duty; for new, modern, small hospital located in Sunny San Luis Valley; 2-hour air service to Denver, Colorado; high, dry climate, perfect for summer and winter sports; salary 7-3, $215; 3-11, $225; 11-7, $240 per month; 2 weeks paid vacation; meals and laundering of uniforms furnished; liberal personnel policies; 5- or 6-day week. For complete information, contact Superintendent, Community Hospital, Monte Vista, Colorado.

NURSES—Psychiatric; men and women; for general duty positions open in a psychiatric wing of a 750-bed hospital. Write, Director of Nursing, Buffalo General Hospital, 100 High Street, Buffalo, New York.

NURSES—General duty; for 600-bed beautifully equipped, rapidly expanding general hospital; beginning salary $234; three weeks vacation and seven holidays with pay, annually; excellent opportunity for advancement; pleasant working conditions. Apply, Director of Nursing Service, Jackson Memorial Hospital, Miami 36, Florida.

NURSES—General duty; 300-bed general hospital; good nurses' home; starting salary $260 per month; 40-hour week; differential for 3-11, 11-7, $10; tuberculosis, obstetrical, and isolation duty $10 extra; Canadian nurses need passport and visa. Director of Nurses, Merced County General Hospital, Box 231, Merced, California.

NURSES—Choice of duty in three modern hospitals; general duty, $239 month to start; surgical, $245 month to start; relief shift, $10 extra; two weeks paid vacation, six paid holidays; medical and hospital benefit plan. Contact Earl L. Jorgensen, Kahler Hospitals, Rochester, Minnesota.

NURSES—Supervising nurse and General duty nurses; Elwyn hospital. Apply, E. A. Whitney, M.D., Elwyn, Delaware County, Pennsylvania.

NURSES—Assistant director, Head, and General duty nurses at state hospital. Apply, Superintendent, State Hospital, Jamestown, North Dakota.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary $250 per month if applicant has advanced preparation or experience; $10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Operating room; fully approved 80-bed general hospital, Pacific Northwest; experience or postgraduate work required; 40-hour week; salary open, depending on experience. MO 85, The Modern Hospital 919 N. Michigan Avenue, Chicago 11.

NURSES—Operating room and Obstetrical; for 250-bed general hospital; eligible for registration in Colorado; excellent personnel policies; beginning salary $227.50, with regular merit increases; maintenance available. Apply, Director, Nursing Service, St. Anthony Hospital, Denver, Colorado.

(Continued on page 214)

HERRICK

STAINLESS STEEL REFRIGERATORS

Performance-Proved

at the new $1,000,000 addition to

ARLINGTON HEIGHTS HIGH SCHOOL

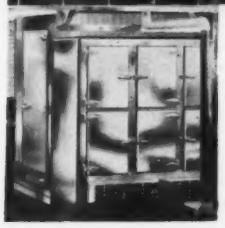
Arlington Heights, Illinois

At left is an exterior view of Arlington Heights High School's new million-dollar addition.

Directly below is an interior view showing the serving center of the new cafeteria.

Architect for the new addition was Carl M. Teutsch, Chicago, Ill.

Superintendent of the school is LeRoy J. Knoeppel.



At left are two HERRICK units serving the high school's new kitchen . . . a HERRICK Stainless Steel Exterior, Porcelain Lined, Self-Contained Reach-In Refrigerator and a HERRICK Walk-In Cooler.

Herrick units were supplied by the Illinois Range Co., Mount Prospect, Ill.

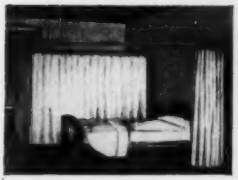
Housing an extra-large, modern cafeteria with a seating capacity of 800 people, Arlington Heights High School's new million-dollar addition makes that institution one of the best equipped in the country. It is practically self-sufficient, having its own laundry, bakery and a kitchen staffed with five employees. • Serving this kitchen is a HERRICK Stainless Steel Reach-In Refrigerator Model SP644B and a HERRICK Walk-In Cooler Model WP766. These HERRICK units assure complete food conditioning day in and day out. For thoroughly dependable performance, convenience and trouble-free service, HERRICK is unsurpassed. Write for name of nearest HERRICK supplier.

HERRICK REFRIGERATOR CO., WATERLOO, IOWA

DEPT. M. COMMERCIAL REFRIGERATOR DIVISION

HERRICK *The Aristocrat of Refrigerators*

HERE'S WHAT YOU GET!



"PRE-FAB" CONSTRUCTION reduces installation time to a minimum . . . no "on the job" fitting required. All rod measuring, cutting, threading, boring, etc., as well as curtain tailoring is completed in the ARNCO plant before shipment. They're really "custom-made"

STRONG, LIGHT, ECONOMICAL—since all parts, tubing, corner bends and fittings are made of aluminum, with Alumilite finish . . . a hard, smooth finish that won't peel, is highly resistant to abrasive wear and atmospheric corrosion.

QUIET OPERATION, NEAT APPEARANCE—The ARNCO plastic roller hooks, to which the curtains are attached, roll back and forth on tracks of Alumilited seamless aluminum tubing, without catching or bending. They move quietly and with perfect ease of operation.

ALL CONNECTIONS THREADED . . . no special tools are needed. In fact, maintenance men agree that ARNCO Cubicles are the *easiest to install.*

ENGINEERED AND BUILT FOR HOSPITAL USE EXCLUSIVELY. ARNCO Cubicles are standard equipment in hundreds of institutions, both large and small, throughout the United States. They are *not* "drapery rod" adaptions. *Write today for latest literature.*

NEW! ARNCO ALUMINUM COAT & HAT RACK

In non-peeling, alumilite finish. Low priced. Strong, economical, easy to install. Write for literature.

A. R. NELSON CO., INC.

210 East 40th Street, New York 16, N.Y.

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POSITIONS OPEN

NURSES—Registered: Hermann Hospital in the Texas Medical Center offers you unlimited opportunities; positions with pleasant working conditions are available now. Write, Director of Nurses, Hermann Hospital, Houston, Texas.

NURSES—Staff and operating room: for 59-bed hospital: straight 8 hours, 6 days a week; rotating service; sickness allowance, two weeks paid vacation; close to Gulf of Mexico. Apply, Lee Memorial Hospital, Fort Myers, Florida.

NURSES—Staff and Operating room: 5 days, 40 hours; 8 holidays and vacation with pay; initial salary $230, plus laundry; increases at 6, 12, 24 months; additional pay for evening and night assignments and for operating room calls. Apply, Director of Nursing, St. Luke's Hospital, New York 25, New York.

NURSES—Staff: for all services including operating room; general hospital; newly constructed 6-floor wing; salary scale at prevailing rate; 40-hour week; paid vacation, sick leave and holidays; P.H.A. insurance and social security benefits. Apply, Director of Nursing Service, Sacred Heart General Hospital, Eugene, Oregon.

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary $265; $5 per month tenure increase for each six months of service to a maximum of $295; social security, sick leave, prepaid medical and hospital care; $10 addtional for afternoon and night shift; $10 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—Staff: for 8-hour, 5-day week, rotating service; salary $255 with full maintenance or $285 one meal and laundry; holidays, sick leave and paid vacation. Apply, Frances Halverstadt, R.N., Superintendent of Nurses, Municipal Contagious Disease Hospital, 3026 South California Avenue, Chicago, Illinois.

NURSES—General staff: for new 18-bed hospital in small, friendly town; salary $250 per month for 40-hour week; eight consecutive hours of duty and rotating shifts; nine paid holidays; two weeks vacation after one year of employment; meals at cost at hospital. Send applications to Administrator, Pioneers Hospital, Meeker, Colorado.

NURSES—General staff: medical, surgical and obstetrical division; new 60-bed hospital in college town, 10,000 population; 41-hour week; 6 paid holidays, paid vacation; $225 monthly, one meal and laundry; position assigned on basis of preference. Write, Director of Nursing Service, Wood County Hospital, Bowling Green, Ohio.

(Continued on page 216)

NURSES—Graduate, staff: for modern 250-bed hospital, fully approved, 70 miles from New York City; forty-hour week; three weeks' paid vacation; sick time; hospital care; merit increases semi-annually; complete maintenance at $45 per month; salary range $200 to $240 per month. Apply, Director of Nursing, Vassar Brothers Hospital, Poughkeepsie, New York.

NURSES—Staff: for a general hospital on medical, surgical and obstetric services; also vacancies on operating room staff; good personnel policies. Apply to Director of Nursing, Buffalo General Hospital, 100 High Street, Buffalo, New York.

NURSES—Staff: for general hospital; 40-hour, 5-day week; $250 with laundry of uniforms; $10 additional for evening, night, maternity duty; increases yearly; must be eligible for registration in California; housing available. Write, Mercy Hospital, Sacramento, California.

NURSES—Staff: for staff, nursery, delivery room; eligible New York registration; 40-hour week; $220 per month; $15 monthly bonus for 4-12 and 12-8 duty; 6-month increment $10; 18 months $10; near Columbia University, making possible part-time study. Director of Nurses, Woman's Hospital, 141 West 109th Street, New York 25, New York.

NURSES—General staff; registered; for 34-bed hospital; salary open. Reed City Hospital, Reed City, Michigan.

Some GAS cooking facts about the BISMARCK HOTEL'S fifty years of fine food

There's no doubt as to the significant contribution of GAS to the quality of food preparation in the Bismarck's six kitchens. Chef Theodore Meyer's simple statement about the all-GAS Cooking Battery is just part of the story—"*Those are good cooking tools, the best to be had. We cook with GAS, the best fuel for cooking.*"

Chef Meyer

The other part of the story of the efficiency, speed, and versatility of the Bismarck's modern Gas Kitchens is just a simple recital of facts about GAS for cooking on large scale or small scale—

- Gas Broiling seals in flavor and vitamins by fast blue-flame action.
- Gas Roasting with precise automatic temperature control produces the maximum quantity of juicy servings.
- Gas Frying insures high speeds with fuel and fat economy.
- Gas Baking provides the finest texture and uniformity of results so important in the preparation of the 87 varieties of baked goods served by the Bismarck.

America's leading chefs agree with Chef Meyer that GAS is the best fuel for every kind of cooking, baking, and food service requirement.

Everywhere from coast to coast you can find these important facts about Modern Gas Cooking Equipment. There's a typical installation nearby which your Gas Company Representative can show you—ask him for details.

Three views of the all-GAS kitchen, equipped with 13 hot-top ranges.

4 double-deck roasting ovens, pastry and bake ovens.

3 open-top ranges, 5 broilers, 7 fryers.

AMERICAN GAS ASSOCIATION • 420 LEXINGTON AVE., NEW YORK 17, N. Y.

classified advertising

POSITIONS OPEN

NURSES—Staff; for a new 123-bed general hospital; ninety miles from Sun Valley; good basic salary and personnel policies. Apply, Director of Nurses, Magic Valley Memorial Hospital, Twin Falls, Idaho.

PHYSICIAN—Resident; for 160-bed hospital; approved general hospital; with or without maintenance; salary open. Apply, Maryview Hosptial, Portsmouth, Virginia.

SUPERVISOR—Central supply; 400-bed hospital; experience in all phases of central supply duties and supervision; salary $245 per month with additional increments according to length of service. Contact Personnel Director, Iowa Methodist Hospital, Des Moines 14, Iowa.

SUPERVISOR—For medical-surgical floor; fully approved 80-bed general hospital in Pacific Northwest; 40-hour week; salary open. MO 83, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR—Obstetrical; fully approved 80-bed general hospital, Pacific Northwest; experience or postgraduate work required; 40-hour week; salary open. MO84, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR — Obstetrical and operating room; postgraduate work desired; new 60-bed hospital in college town, 10,000 population; $240 monthly, one meal and laundry; pay for call and overtime; 6 paid holidays, paid vacation. Write, Director of Nursing Service, Wood County Hospital, Bowling Green, Ohio.

SUPERVISOR—Operating room; for 100-bed general hospital, located in southwest Virginia; excellent working and living conditions; salary open. Apply, Superintendent of Nurses, Pulaski Hospital, Pulaski, Virginia.

SUPERVISOR—Pediatrics; salary for degree and experience, $3804 to $4164; retirement program and social security; 441-bed hospital in a beautiful 40-acre park; liberal personnel policies. Apply, Director of Nurses, Reading Hospital, Reading, Pennsylvania.

SUPERVISORS—Two assistant night supervisors capable of taking charge in delivery room; 44-hour week; gross salary, $210-265; may live in residence. For full particulars, apply, Superintendent of Nurses, General Hospital, Moose Jaw, Saskatchewan, Canada.

TECHNICIAN — Laboratory; non-registered; for approved general 200-bed hospital in Midwest; salary range from $214.50 to $240.50; nice working conditions. MO 92, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

TECHNICIAN—X-ray; female; for 110-bed hospital. Mrs. Probandt, Belmont Hospital, 4058 West Melrose Street, Chicago 41, Illinois.

TECHNICIAN — Laboratory; registered; approved hospital has an opening that pays from $266.50 to $318.50; city of 75,000; write for more information—let us tell you more about this opening. MO 93, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

TECHNICIAN—Laboratory; registered; 150-bed general hospital in progressive city of 40,000, Pacific Northwest; department well equipped; three technicians under supervision of pathologist. MO 5, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

TECHNICIAN—Laboratory; one with experience in supervision, in the training of those who will assist and in instructing students; this position is open and presents a real opportunity; general approved hospital, 200 beds; well equipped department; nice living quarters available nearby; salary range from $325 to $377. MO 94, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

TECHNICIANS—Laboratory. For further information, write J. O. Collins, M.D., Pathologist, Waterbury Hospital, Waterbury, Connecticut.

(Continued on page 218)

classified advertising

POSITIONS OPEN

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS—(a) University hospital, fairly large size, currently under construction; building experience advantageous, not required; university medical center. (b) Medical; new medical center; Pacific coast. (c) General 365-bed hospital; expansion program; coastal city, south. (d) General hospital over thousand beds, affiliated medical school; should be qualified develop teaching and research center. (e) Medical director and assistant superintendent; 700-bed teaching hospital; large city, medical center. (f) General hospital, 200 beds; New England. (g) Lay or medical; voluntary general hospital, 300 beds; university city, east; $15,000-$20,000. (h) Small community hospital; resort area of West; accounting background helpful. (i) New hospital currently under construction; east; $10-$15,000. (j) Assistant director in charge of business management; 400-bed hospital, affiliated medical school; building program; accounting and substantial business background required; $8000. MH10-1.

MEDICAL BUREAU—*Continued*

ADMINISTRATORS—NURSES. (a) Beautiful new hospital, 85 beds; residential town, near university city, east. (b) General hospital, 60 beds; small town, near large city, university medical center, southwest. (c) Crippled children's hospital; expansion program; $6500, maintenance. (d) Assistant administrator; 300-bed hospital; midwest. MH10-2.

ANESTHETISTS—(a) Two; new general hospital, 100 beds; residential town, near university city, south; $500. (b) General 250-bed hospital; medical anesthesiologist in charge; university city, east. MH10-3.

COLLEGE, STUDENT HEALTH—(a) Health coordinator and recreational director; fairly large hospital; near Chicago. (b) College; young women's college; near New York City. MH10-4.

DIETITIANS—(a) Chief; new voluntary general hospital; department staff, 35; minimum, $350, complete maintenance including apartment; near New York City. (b) Small general hospital; residential town, near San Francisco. (c) Director, nutritional services, health agency, West Indies. (d) Assistant administrative dietitian; residence hall for men, state university; midwest. (e) Managers and assistant managers, restaurant chain; opportunities available, midwest, south, southwest. (f) Therapeutic and teaching dietitians; one of Chicago's leading hospitals. MH10-5.

(Continued on page 220)

MEDICAL BUREAU—*Continued*

DIRECTORS OF NURSES—(a) University school; woman of outstanding qualifications, Master's or Ph.D., qualified develop four-year program; $7000-$8000. (b) Voluntary general hospital, 225 beds, expanding to 300; 70 students; well staffed; California; minimum $6000. (c) General 200-bed hospital; university affiliations; $6000, maintenance, attractive apartment; east. (d) General hospital 300 beds; 110 students; college town, midwest; minimum $5000, complete maintenance including private apartment. (e) Director and assistant director, nursing service; new general hospital, 200 beds, currently under construction; completion January; college town, 40,000, south. (f) Nursing service only; 200-bed general hospital; college town, northwest; $6000, maintenance. (g) Nursing service only; new tuberculosis hospital affiliated with university, located on its campus; faculty rank; assistant professor; minimum $6000. (h) Associate director, nursing service; voluntary general hospital, 550 beds; university affiliations; large city; university medical center; west. MH10-6.

EXECUTIVE PERSONNEL—(a) Public relations director; voluntary general hospital, 300 beds; large city, university medical center, midwest. (b) Coordinator volunteer services; large teaching hospital; west. (c) Chief accountant; voluntary general hospital, 300 beds; New England. (d) Personnel director, voluntary general hospital, 225 beds; 200 personnel; midwestern city having two medical schools. (e) Maintenance and engineering supervisor; new general hospital currently under construction; 200 beds, east. MH10-8.

ONCE OVER replaces 12* ordinary cleaners!

OnceOver, a product of Gerson-Stewart research, makes possible the perfect meeting of every cleaning need—with ONE cleaner.

Wood, metal, paint, glass, porcelain . . . it cleans them all. **OnceOver** is completely safe to use on any surface or material that water alone will not harm. It is non-odorous.

With **OnceOver** you can discard your collection of "specialized" cleaners, simplify your cleaning methods, eliminate laborious scrubbing, reduce your stock, cut storage costs...and get vastly superior over-all cleaning.

Ask your G-S representative to tell you about **OnceOver** (or other G-S systematized sanitation methods and products) or write direct for descriptive literature.

A-6055

*A recent survey of 26 OnceOver users shows that this new cleaner is replacing from 7 to 16 previously used "specialized" sanitation materials.

the Gerson-Stewart Corp.

Sanitation Specialists Since 1914 • CLEVELAND 4, OHIO

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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

EXECUTIVE HOUSEKEEPERS—(a) Voluntary general hospital, 600 beds; university center, midwest. (b) Important hospital, fairly large size; Florida. MH10-7.

FACULTY POSTS—(a) Educational director and clinical instructors in medicine, surgery, pediatrics; collegiate school; university city, Pacific coast. (b) Assistant professor psychiatric nursing; large coeducational institution; east; minimum $5000. (c) Assistant professor, nursing arts; state university, 11-month year; around $5000; midwest. (d) Assistant director in charge of outpatient nursing service, qualified to serve as director of health and welfare; one of country's largest teaching institutions. (e) Science instructor; new general hospital, 450 beds; east. (f) Educational director; one of Wisconsin's leading hospitals; minimum $400. MH10-9.

MEDICAL RECORD LIBRARIANS—(a) Chief; new general hospital, 300 beds; university and seaport town, 100,000, south. (b) New hospital; college town, California. (c) Chief; voluntary general hospital; 200 beds; vicinity New York City. (d) Chief; one of leading hospitals, Chicago area. MH10-10.

MEDICAL BUREAU—*Continued*

PHARMACIST—Voluntary general hospital, 400 beds; minimum, $350, complete maintenance including house; college, resort town. MH10-11.

SUPERVISORS—(a) Operating room; new 300-bed hospital affiliated with diagnostic clinic; residential town near university center, east. (b) Central supply; general 300-bed hospital; university center, west. (c) Surgical; teaching hospital operated under American auspices, Asia. (d) Outpatient, operating room, obstetrical and central supply; voluntary general hospital currently under construction, completion midwinter; will serve several residential communities; east. (e) Surgical; relatively new hospital, Los Angeles area; $4200-$4500, transportation refunded after year's service. (f) Pediatric; fairly large general hospital; university and resort town, Gulf Coast. (g) Outpatient; teaching hospital; university city, midwest. MH10-12.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ASSISTANT ADMINISTRATORS—(a) 200-bed hospital, near New York. (b) 200-bed hospital, Michigan. (c) 175-bed hospital, New England.

(Continued on page 222)

INTERSTATE—*Continued*

ADMINISTRATORS—(a) 135-bed hospital-clinic; southwest; well equipped; outstanding medical staff; $10,000. (b) 80-bed hospital, industrial community, east. (c) 125-bed hospital, eastern Pennsylvania. (d) 90-bed hospital, south. (e) 50-bed hospital, Ohio.

BUSINESS MANAGERS—(a) 125-bed hospital, Kansas. (b) 65-bed hospital, Colorado. (c) 150-bed Florida hospital. (d) 260-bed hospital; university city, south.

DIRECTORS OF NURSING—(a) 225-bed hospital, near Baltimore; to $6000, maintenance. (b) 175-bed Ohio hospital; $5400, maintenance. (c) 125-bed hospital, south central state; $5600, maintenance; medical center.

DIRECTOR, PRACTICAL NURSE PROGRAM—University center, central state; $5000.

CHIEF MEDICAL RECORD LIBRARIANS—(a) 225-bed hospital, midwest; $4800. (b) Large eastern hospital; $4200. (c) 165-bed hospital, Ohio; $350.

TECHNICIANS—(a) Laboratory; $325. (b) X-ray; $200, maintenance. (c) Laboratory and X-ray; $225-$285, maintenance.

ANESTHETISTS—$350-$500, maintenance.

DIETITIANS—(a) Administrative; $375, maintenance; 200-bed hospital, midwest. (b) Therapeutic; $250-$275, maintenance. (c) Cafeteria supervisors; $300.

classified advertising

INTERSTATE—*Continued*

PHARMACISTS—(a) Chief; 300-bed midwestern hospital. (b) Chief; 400-bed hospital, east. (c) Assistant; 250-bed Michigan hospital.

EXECUTIVE HOUSEKEEPERS—(a) 225-bed hospital, New York state; $250. (b) 200-bed hospital, Texas. (c) 175-bed hospital, Ohio. (d) Tuberculosis sanatorium, midwest.

ADMINISTRATORS—(a) Medical; very large teaching hospital; $15,000; east. (b) Lay; assistant; 350-bed, general hospital affiliated university medical school; preferably under 40 with hospital residency; no accounting work; large university medical center; pleasant living; about $8000; midwest. (c) General hospital; 300 beds, currently in planning stage; will consider consulting or full time basis; midwest. (d) Lay; assistant; full charge all business procedures; 550-bed teaching hospital; northeast. (e) Medical; 125-bed general hospital; large city, west. (f) Lay; 180-bed general hospital; attractive town 50,000, half hour from important university medical center; north central. (g) Lay or medical; new 150-bed, voluntary general hospital; east. (h) Lay or medical; general voluntary hospital; 170 beds; near large very important medical center city; east. (i) Lay; 140-bed general voluntary hospital; university city 300,000; west. (j) General hospital; 130 beds; Ohio. (k) Lay; 100-bed general hospital; desirable town, 40,000, near New York City. (l) Lay; 100-bed general hospital; new post; town 100,000; New England. (m) Lay; 100-bed general hospital; completion, spring 1953; university city; west coast.

WOODWARD—*Continued*

ADMINISTRATORS—NURSES. (a) Hospital currently under construction; general, 150 beds; $5000-$7500; east. (b) Young nurse with some administrative background; modern, new convalescent 40-bed unit; $4000; Boston area. (c) Assistant; 375-bed woman's hospital; university medical center; midwest. (d) Small general hospital doubling in size; 50 beds; southwest.

(Continued on page 224)

WOODWARD—*Continued*

ANESTHETISTS—(a) New, general, air-conditioned hospital; foreign operations; leading industrial company; $7300. (b) Small modern hospital; private fee basis; should net $650 month; midwest. (c) Qualified, oral surgery anesthesia; office of prominent D.D.S.; $450; 40 hours; large city; Florida. (d) Large teaching hospital; three in department; $500; Chicago. (e) Distinguished group 22 specialists; $500; Iowa. (f) General hospital; 50 beds; $450, full maintenance; Washington, D.C., area.

COLLEGE, STUDENT HEALTH—(a) To head department, volunteer work; 1000-bed university hospital; requires ability in public relations; mideast. (b) Certified public health nurse; some teaching; state teacher's college; excellent faculty; 2000 students; coeducational; midwest. (c) Director, health service; 350 students; several assistants; excellent college; substantial; New York.

DIETITIANS—(a) Chief; 300 meals; excellent hospital; coastal city, California; $4800. (b) To organize and head a pay cafeteria; general hospital, 650 beds; substantial salary; northeast. (c) Chief; general hospital; 225 beds; $6000; east. (d) Chief; general hospital; 500 beds; minimum $4200, full maintenance; university medical center one million; midwest. (e) Chief; general teaching and research hospital; $5000, full maintenance; large city; east.

AMERICAN-Standard

First in heating...first in plumbing

Architect: Percy McGhee
General contractor: R. E. McKee
Mechanical contractor: Brown & Olds Plumbing and Heating Co.
Wholesale distributor of heating and plumbing: Electrical and Mechanical Supply Co.

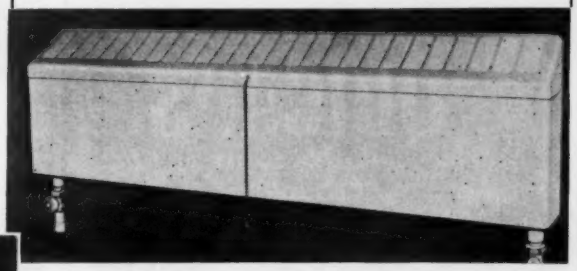
AMERICAN-Standard Heating Equipment and Plumbing Fixtures serve the Hotel Dieu Hospital of El Paso, Texas

AMONG the noteworthy features of the new, modern Hotel Dieu Hospital of El Paso, Texas, are its scientifically-styled plumbing fixtures and efficient, dependable heating equipment by American-Standard.

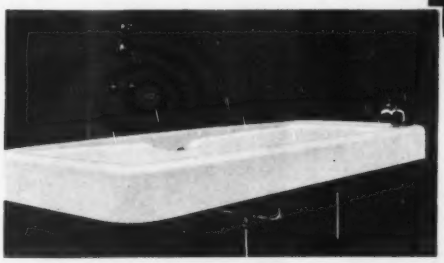
In all types of hospitals throughout the country American-Standard products have proved invaluable in making patients more comfortable, and in facilitating the tasks of hospital attendants. And they have earned a reputation for outstanding service, durability and easy maintenance wherever used.

There's a *complete line* of American-Standard heating equipment and plumbing fixtures to choose from. You're sure to find the *right* products for your particular needs, whether your hospital is large or small, new or modernized.

• These American-Standard Surgeons' Scrub-up Sinks are easy to use and easy to clean. They have deep bowls, goose-neck spouts with spray nozzles, and knee-action mixing valves. Sturdily constructed of non-absorbent genuine vitreous china, the smooth-surface sinks will retain their lustrous good looks indefinitely.



• New Multifin Convectors assure outstanding heating comfort for the Hotel Dieu Hospital. These non-ferrous convectors give dependable, uniform warmth with steam or hot water. Attractive cabinets are unobtrusive. New Multifin Convectors come in sizes to meet virtually every heating need.



• Typical of the specialized American-Standard products supplied El Paso's Hotel Dieu Hospital is this Autopsy Table. It is made of cast iron smoothly finished in acid-resisting enamel. The table is equipped with twin drain, hose spray, and painted steel support with leveling flanges.

American Radiator & Standard Sanitary Corporation, P. O. Box 1226, Pittsburgh 30, Pa.

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POSITIONS OPEN

WOODWARD—*Continued*

DIRECTORS OF NURSES—(a) Nursing service: 700-bed hospital opening early in 1953; requires minimum four years experience; minimum $6000; desirable college town, 130,000; (b) Preferably with Master's in pediatrics and experience in children's hospital; new 100-bed children's hospital planning 200-bed addition; well endowed; $6000; city 130,000; southwest. (c) Nursing service and education; general hospital; 150 beds; affiliations in sciences, pediatrics and psychiatry; $6000, complete maintenance; lovely university town, 30,000; southeast. (d) Nursing service; new 200-bed hospital; large city; California.

EXECUTIVE HOUSEKEEPERS—(a) General hospital, 300 beds; desirable college town, 110,000; Indiana. (b) General hospital, 250 beds; west-mountain. (c) General hospital, small size; Los Angeles area. (d) 700-bed teaching hospital; large city, south.

MEDICAL RECORD LIBRARIANS—(a) Chief; 600-bed hospital; medical school affiliations; substantial; New York City. (b) Chief; To reorganize department; fairly large woman's hospital; university medical center; central. (c) Chief; group fifteen distinguished specialists; excellent clinic-hospital; university city; south.

WOODWARD—*Continued*

FACULTY POSTS—(a) Educational director; to coordinate university program; $5000, south. (b) Educational director; 300-bed hospital; Los Angeles area. (c) Assistant professor; clinical coordinator, obstetrics, pediatrics; large college; central. (d) Clinical instructor in pediatrics; teaching hospital; east. (e) Nursing arts instructor; leading California hospital; outstanding faculty. (f) Nursing arts instructor; university hospital; south. (g) Science; small hospital; 35 students; $4000, full maintenance including nice apartment; prefer degree but not essential; New England.

SUPERVISORS—(a) Neurological; 400-bed teaching hospital; requires degree on level of Bachelor's; New York City. (b) Central supply; prefer one registered; supervise 10 employees; 350-bed general hospital; city 200,000; midwest. (c) Medical and surgical floor; large general hospital; town 70,000, seven miles from New York City. (d) Medical-surgical unit; general hospital, medium size; town 50,000; Pacific Northwest. (e) Obstetrical; administrative and teaching; general hospital; 400 beds; resort town, 100,000; New England. (f) Operating room; fairly large tuberculosis hospital; Alaska. (g) Surgical; small general hospital; $4500; transportation; Los Angeles area. (h) Operating room; general hospital, 200 beds; Florida resort. (i) Pediatric; teaching hospital; New York City.

(Continued on page 226)

BUSINESS AND MEDICAL REGISTRY
(Agency)
Elsie Miller, Director
610 South Broadway, Room 1105
Los Angeles 14, California

DIETITIANS—(a) Administrative; 225-bed county hospital, central California near national parks; $3900; 40-hour week; liberal vacation, 11 annual holidays. (b) Therapeutic; attractive beach location near Los Angeles; $3600; (c) Dietitians of experience, not members of ADA, desired for some of our positions.

INSTRUCTOR—Needed for approved vocational nurses' training program in large California hospital; degree required; no week-end duty; $3900.

MEDICAL RECORD LIBRARIANS—Several positions open in southern California hospitals; scenic surroundings; tempting salaries.

MEDICAL SECRETARIES—Clinics, groups, hospitals and physicians in southern California need experienced secretaries; starting salaries, $3400-$3600.

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ADMINISTRATOR—Well known hospital and clinic; will have complete charge of hospital and clinic with exception of the business office, which has a business manager who has been with them a number of years; administrator will be responsible only to the Board for the operation of the hospital; $10,000.

ASSISTANT DIRECTOR IN CHARGE OF BUSINESS MANAGEMENT—East; 400-bed hospital; will have supervision of the following functions: accounting, payroll, credit and collections, purchasing, maintenance and housekeeping; each of these functions has an operating department head; director will plan, control and coordinate the functions of these departments; position carries excellent potentialities for future advancement; salary, $8000 minimum to start.

CHIEF DIETITIAN—East; 215-bed hospital, fully approved; ideally located in New England city of 35,000; duties all administrative; $6000 plus maintenance including a modern 3-room apartment.

SHAY—*Continued*

DIRECTORS OF NURSES—(a) East; 110-bed hospital in city of 17,000, easily accessible to New York City. (b) Southwest; 165-bed hospital in city of 70,000; degree required; $6000. (c) East; 215-bed hospital in city of 25,000; degree required. (d) Middle west; 500-bed hospital in large city; $7200.

MEDICAL PERSONNEL EXCHANGE
Nellie A. Gealt, R.N., Director
4707 Springfield Avenue
Philadelphia 43, Pennsylvania

PATHOLOGIST—New 200-bed hospital, to open shortly; north central location; to $22,000.

LABORATORY TECHNICIAN, CHIEF—New position; large general hospital, east; Master's in Science, and experience required; salary commensurate with ability.

MEDICAL SOCIAL WORKERS—(a) Director; 390-bed hospital. (b) Staff; 371-bed hospital.

PHYSICAL THERAPIST—Male or female; $3800 plus full maintenance; 40-hour week.

OCCUPATIONAL THERAPISTS—New 100-bed psychiatric hospital; substantial salaries.

No charge for registration

(Continued on page 228)

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ZINSER PERSONNEL SERVICE
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(Continued on page 230)

ASSOCIATED MEDICAL PERSONNEL BUREAU
Don A. Thompson, Director
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Should you want to change your position for betterment, we shall undertake to place you IN THE LOCALITY OF YOUR CHOICE—anywhere in the United States. Send us your qualifications. Tell us where you prefer to work. When accepted by us, you will find our placement service confidential, ethical, effective—and personalized to your individual need. No charge for registration. Write us today.

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SCHOOLS—SPECIAL INSTRUCTION

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and a stipend of $60 a month provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

SCHOOL FOR LABORATORY TECHNICIANS —Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Mo.

The MARGARET HAGUE MATERNITY HOSPITAL. The largest hospital in the country offers the following to registered, professional nurses of accredited schools:

Four Months' Course:

Included are obstetric lectures, nursing classes, techniques, laboratory science, nutrition, mothers' health and socio-economic aspects. Supervised experience is given in antepartal, intrapartal, postpartal and newborn infant care with a minimum of twenty-five hours of clinical instruction. Students may elect one month's experience in premature nursery, formula room, isolation, antepartal or clinic and field service.

Six Months' Course:

Following the above program, a two months' course is offered to students who have demonstrated potentialities for head nurse responsibilities. It includes instruction in principles and methods used in clinical teaching program and ward management. Students plan and conduct their program of clinical instruction with the head nurse and serve as assistants. They are directed and supervised by the instructor of the course.

Classes admitted every other month beginning February. Maintenance and stipend of $75.00 per month granted. Write for catalogue. Address Rose A. Coyle, R.N., Director of Nurses, 88 Clifton Place, Jersey City 4, New Jersey.

How should a hospital breathe?

Many hospitals today have air conditioning of one sort or another. But in a really modern hospital, you'll always find a Carrier Conduit Weathermaster System.

That's because this air conditioning system breathes better. It inhales outside air at *one* place . . . not through many holes in the walls of the building.

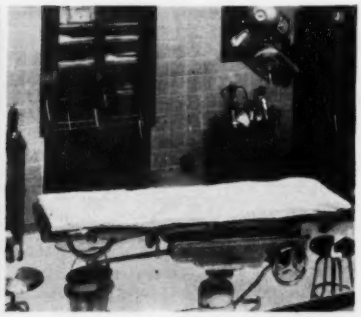
The advantages? Plenty of them. Take the Carrier Conduit Weathermaster air conditioned Methodist Hospital down in Houston. Because it has one main primary air intake, all the mechanical equipment that filters, conditions, dehumidifies and circulates air is centralized.

So there are no noisy motors or fans in patients' rooms . . . no wet, dripping coils or filters to be changed. The central equipment sends conditioned, cleaned, dehumidified air through the building in small conduits and diffuses it gently into the rooms.

On the job year round, the Carrier Conduit Weathermaster System at Methodist cools in summer, heats in winter. In spring and fall it prevents that "clammy" feeling that other systems can't avoid . . . because they can't control both temperature and humidity. Carrier Corporation, Syracuse, New York — *for 50 years . . . the people who know air conditioning best.*

Carrier

AIR CONDITIONING
REFRIGERATION
INDUSTRIAL HEATING



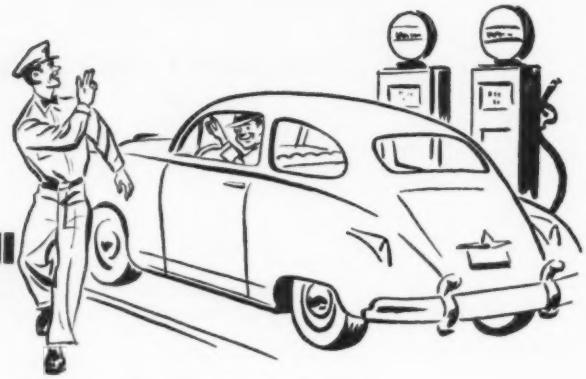
There are eleven operating rooms at Methodist Hospital, all Carrier air conditioned and equipped with facilities for televising operations.

Patients have individual control of room temperature. And there are no filters, noisy motors or fans in the rooms to be serviced.

"SEE YOU AT THE POLLS!"

"SEE YOU AT THE POLLS!"

"SEE YOU AT THE POLLS!"



Nobody knows for sure how it started—this line about "See you at the Polls!" we're hearing all over these days.

Best explanation seems to be that it came from that state candidate out west. . . . His opponent in a debate got all riled up and challenged him to fight it out in the alley.

But he said—"I'll settle this the AMERICAN way—I'll see you at the polls!" And the audience picked up the chant.

Now everybody's saying it—and on Nov. 4 everybody will be *doing* it!

"SEE YOU AT THE POLLS!"

"SEE YOU AT THE POLLS!"

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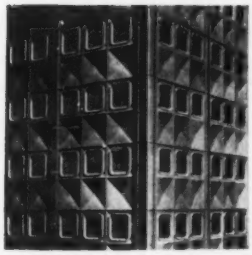

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● The headquarters building of **ALUMINUM COMPANY OF AMERICA**, now nearing completion in the heart of **PITTSBURGH'S GOLDEN TRIANGLE**, embodies so many innovations as to defy comparison with any other structure now existing. Its exterior is made up of formed aluminum panels of inverted pyramidal pattern, with pivoted, aluminum-framed windows set in. Some of the other unusual uses of aluminum are the ceiling-installed radiant heating and cooling system . . . the ceiling finish panels perforated for acoustical control . . . the water storage and distribution system . . . and electrical conduit, wiring and lighting fixtures. Coupled with the many innovations are products of long-established superiority, such as **SLOAN *Flush* VALVES**, famous for efficiency, endurance and economy. As in thousands of other notable buildings, here is proof of preference that explains why . . .

***more* SLOAN *Flush* VALVES**
are sold than all other makes combined

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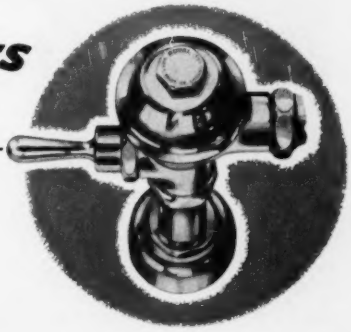

Another achievement in efficiency, endurance and economy is the **SLOAN** *Act-O-Matic* **SHOWER HEAD**, which is automatically self-cleaning each time it is used! No clogging. No dripping. When turned on it delivers cone-within-cone spray of maximum efficiency. When turned off it drains instantly. It gives greatest bathing satisfaction, and saves water, fuel and maintenance service costs.

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PROVED WORKMANSHIP . . . North Star has had 88 years of experience in blanket engineering . . . weaving contract blankets to strictest specifications. Our customers have had 88 years of solid satisfaction. Won't you consult us on your blanket requirements —soon?

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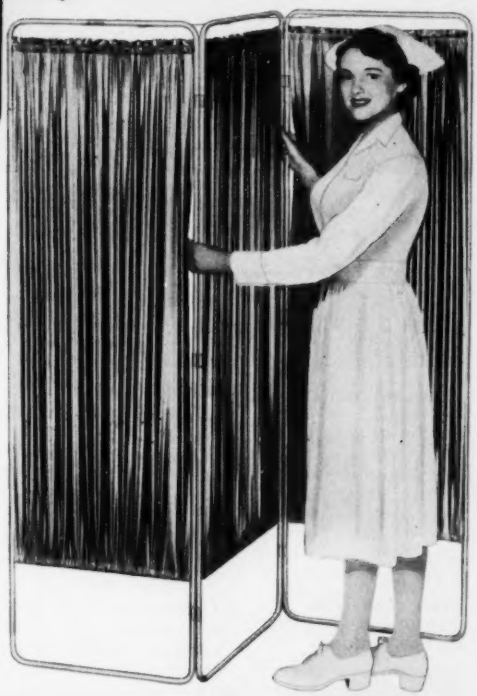
HOSPITAL SCREEN

gives you 7 real advantages!

***Write** for swatches which show the true beauty of these Vinyl panels.*
Address ***PRESCO COMPANY, INC., Hendersonville, N.C.***



Lightweight • The lightest all-purpose hospital screen ever designed—only 4½ pounds! So easy to lift or move or store.

Sturdy • One-piece tubular aluminum frame, anodized for lifetime satin finish. Glider base plus self-locking hinges make this screen virtually tip-proof.

Easily Maintained • Panels of durable Goodyear Vinyl require no laundering. They can be cleaned in a jiffy with light germicidal solution—without removing from frame. "Snap-out" curtain rods permit split-second replacement of panels.

Eye Appeal • Beautiful Vinyl panels in a variety of cheerful colors—blue-gray, pastel rose, pastel green, or white. Also, a new nursery design with gay circus characters. Satin-finish aluminum frame.

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Low Cost • Compare this PRESCO *feather-lite* Screen, feature for feature, with any other. Then compare costs. The PRESCO Screen, complete with Vinyl panels—only **$39.50**! Extra screen panels, **$2.00** each. (Without panels, **$36.00**)

PRESCO *feather-lite* SCREEN

PRESCO IDENTIFICATION SYSTEM

. . . for easier, faster, positive identification

• For both baby and adult patient identification, the PRESCO SYSTEM provides positive identification with minimum preparation and application time. Soft, pliable plastic bracelet (pink, blue, or white) slipped around wrist or ankle. Won't come off until cut off. Paying for itself in hundreds of hospitals. *Write for Free Samples.*

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Terrell State Hospital, Terrell, Texas. Tatum & Quade, Dallas—Architects

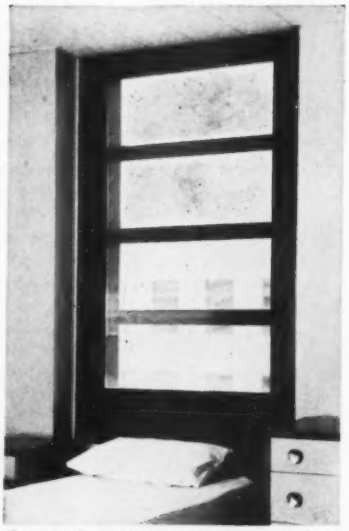
Exterior view of beautiful Terrell State Hospital, Terrell, Texas. In addition to 910 Chamberlin Detention Screens, 898 Chamberlin Insect Screens were chosen.

Here's what you buy when you specify Chamberlin Security Screens

Here, in brief, are the daily services and savings provided by Chamberlin Detention, Protection, and Safety Screens. Measure these important product benefits against your security-screen needs:

- They provide safe, sure, humane detention and protection year after year. This has been borne out by hundreds of satisfied users.
- They reduce building and grounds maintenance costs by eliminating glass breakage and grounds littering by patients. They double as insect screens.
- They reduce screen maintenance costs. They are the heaviest, most rugged screens made, with extra-thick steel frames and tough, double-crimp, stainless-steel wire mesh that resist severe attacks and usual forcing, picking and prying.

Chamberlin's Advisory Service can save you money in many unexpected ways, will work directly with you on your security screen problems for both present and future. Write for informative folder on Chamberlin Security Screens — Detention, Protection, and Safety types — or let us give you exact data on your specific needs.



Chamberlin Detention Screen in Terrell State Hospital. Chamberlin Screens admit abundant light and air, blend well with interior trim. Attendant's key opens hinged section for easy cleaning.

OTHER CHAMBERLIN INSTITUTIONAL SERVICES INCLUDE:

Chamberlin All-Metal Combination Windows reduce fuel bills up to 30%. Insect screens also available.

Chamberlin Rock Wool insulation keeps buildings up to 15° cooler in summer, saves fuel in winter.

Chamberlin Plasti-Calk seals off leaks around window and door frames, reduces structural deterioration.

Chamberlin Metal Weather Strips reduce air leakage, eliminate window rattle, save fuel.

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Special Products Division

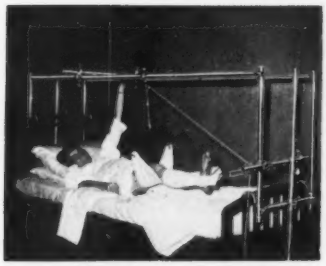
1254 LA BROSSE ST. • DETROIT 32, MICHIGAN

What's New for Hospitals

OCTOBER 1952 Edited by BESSIE COVERT

TO HELP YOU get information quickly on new products described in this section, we have provided the convenient Readers' Service Form on page 280. Check the numbers of interest to you and mail the coupon to the address given on the form. If you wish other product information, just list the items and we shall make every effort to supply it.

Overbed Frame



The new Stryker Universal Overbed Frame can be attached to any ordinary bed or crib. The light weight but durable frame can be quickly assembled or dismantled and is easy to store when not in use. Only one person is needed to assemble the chromium plated parts. The bed end clamps will fit the ends of any bed and are plastic covered to prevent marring.

The overbed frame can be used as a grasping bar for the patient, as, in effect, a Balkan frame, and for other overbed frame purposes. The frame may be purchased in units and can be assembled to suit any need. It is a sturdy, light weight, economical unit requiring no accessories to convert any bed for traction and other orthopedic needs. **Orthopedic Frame Co., Dept. MH, 420 Alcott St., Kalamazoo, Mich. (Key No. 319)**

Melmac Orthopedic Composition

A new orthopedic cast material known as Melmac Orthopedic Composition has been introduced after considerable research and experiment. Thin, light weight casts can be made which provide adequate immobility and support within a few hours after application. Casts made with the new composition are sufficiently porous to permit evaporation of moisture from the skin. Greater x-ray penetration is also possible and continued observation of the patient's progress is simple and accurate.

The new Melmac Orthopedic Composition casts are water and urine resistant and may be soaked for several days in water without disintegrating. Plaster loss is reduced and fewer bandages need be applied. Clinical tests involving the application of over 800 casts showed absence of irritating effects attributable to the Melmac, according to the manufacturer. The solution is easily prepared and attendants do not need gloves to apply the bandages dipped in the solution. **Davis & Geck, Inc., Division of American Cyanamid Co., Dept. MH, 57 Willoughby St., Brooklyn 1, N. Y. (Key No. 320)**

Elastic Hosiery for Men

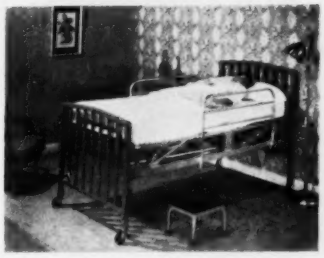
Ace Full-Footed Elastic Hosiery is now available for men. Made of seamless, light weight, nylon-covered latex which closely resembles highest quality nylon dress hose, the new full-footed Ace Elastic Hosiery is comfortable, therapeutically correct and handsome in appearance. A "built-in" two-way stretch provides gentle but persistent support to the entire leg and foot. Firm anchorage is provided by the specially woven latex heel which also prevents swelling. The non-elastic nylon toe assures flexibility, ease and comfort without cramping the toes.

No overhose are necessary with the new Ace Elastic Hosiery for men as the

ankles fit smoothly without wrinkling or excessive bulk and the hose are available in deep burgundy color. A two-inch adjustable cuff holds the hose in place without constriction so that garters are not necessary. The new hose are available in sizes 10, 11, 12 and 13. **Becton, Dickinson & Co., Dept. MH, Rutherford, N. J. (Key No. 321)**

(Continued on page 238)

Half-Size Safety Side



As assurance to patients unaccustomed to the higher and narrower hospital bed, the new Simmons Half-Size Safety Sides can be used at night to protect against the patient accidentally rolling over and falling out of bed. They also provide a safety "reminder" during the day for patients who do not require full size safety sides. The patient does not have the sense of confinement often present with full sized safety sides. The H-49 Half-Size Safety Sides also provide a brace for the patient in raising or lifting himself in bed, yet the convalescent or ambulatory patient can easily get out of bed without the sides being removed.

The H-49 is constructed of all metal tubing and is attached to the bed frame by means of simple bolts. The Half-sides are light in weight and can be attached to the bed easily by one person. They provide inexpensive safety for the patient and ease of mind to personnel without the constriction of full sides. **Simmons Co., Dept. MH, Merchandise Mart, Chicago 54. (Key No. 322)**

Conductive Foot Stool

Designed to minimize explosion hazards in the operating room, the new Winfield Model Stainless Steel Foot Stool has electrically-conductive floor tips and an electrically-conductive rubber tread. The leg design prevents the stool from tipping and the legs are reinforced by a welded T-shaped brace for added strength and stability. It is available in three sizes: 10 by 14 inches, 12 by 18 inches and 12 by 30 inches. **S. Blickman, Inc., Dept. MH, Weehawken, N. J. (Key No. 323)**

What's New . . .

Disposable Administration Set

The VAS-10 is a new disposable sterile vented administration set for hospital made solutions with flasks using single opening stopper. It is sterile, pyrogen

free, non-toxic and leakproof and is ready for use except for sterile recipient needle. The disposable sets eliminate the necessity for cleaning, sterilizing and assembling hospital made sets.

Each administration set consists of plug-in with foolproof ball check valve, accurate drip chamber, extra long length of tubing, section of latex tubing for supplemental medication and nylon needle adapter. The individually packaged and sealed sets have instructions printed on each package and offer simplified technic, compact storage and saving in labor. The sets are made by Sterilon for exclusive distribution by **American Sterilizer Co., Dept. MH, Erie, Pa. (Key No. 324)**

Heat-Absorbing Glass

Pennvernon Solex is a flat drawn sheet glass with the functional heat-absorbing, glare-reducing characteristics of Solex. It is a greenish tint heavy flat drawn glass in $\frac{7}{32}$ inch thickness manufactured to reduce the intensity of solar radiation without sacrificing the light transmission characteristics of high quality glass. It reduces interior heat of rooms with windows in direct sunlight and the pleasant greenish tint softens light intensity and reduces glare. **Pittsburgh Plate Glass Co., Dept. MH, 632 Duquesne Way, Pittsburgh 22, Pa. (Key No. 325)**

Bronchus Clamp

Especially designed for use in pulmonary resection, the new Rubin Bronchus Clamp is usable for either the right or left bronchus, singly or in pairs, and is not impeded by solid lung tissue. It is designed to eliminate many of the technical difficulties involved in the clamping, division and closure of the bronchus and may be used with equal facility regardless of the position of the patient on the operating table. The clamp is available in three sizes. **J. Sklar Mfg. Co., Dept. MH, 38-04 Woodside Ave., Long Island City 4, N. Y. (Key No. 326)**

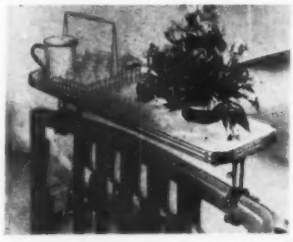
Surgiset, Jr.

Surgiset, Jr. is an addition to the Ethicon Surgiset emergency suture unit. Individual bottles with sturdy, non-tip bases contain one dozen sterile Ethicon Cuticular sutures each, ready for instant use. Atraloc eyeless needles are swaged to the surgical gut, silk, dermal and nylon to provide non-traumatic sutures to meet the requirements of emergency repair. The unit, base and one dozen sutures, is offered at the same price as the sutures alone. **Ethicon Suture Laboratories Incorporated, Dept. MH, New Brunswick, N. J. (Key No. 327)**

Special Diet Foods

A new line of Special Diet Foods is being made available containing Abbott's Sucaryl Calcium as a sweetening agent. Thirty times sweeter than sugar, the product has no disagreeable after taste and is offered for diabetic, cardiac, kidney and overweight patients when a low sodium, sugar-free, low calorie diet is prescribed. Seidel's Special Diet Foods were developed in consultation with chemists and dietitians. They include soup bases, gelatin desserts and beverage concentrates, packed in convenient jars and bottles. All products are easy to prepare and heating does not injure their palatability. **Ad. Seidel & Son, Inc., Dept. MH, 1245 W. Dickens Ave., Chicago 14. (Key No. 328)**

Bed-End Utility Table



A new table for the use of the nurse, which is out of the patient's way, is offered in the new Bed-End Utility Table. The table is attached with either clamps or steel rods, depending on the bed model, to the foot end of the bed and provides an extra space for holding flowers, medicine trays and other items. The table is strong and firm and built to hold an unusual amount of weight. It has a Formica top which does not scratch, scar, burn or chip and can be washed with soap and water. The table has a protective, decorative metal band around the edge. It is oval in shape, 30 inches long, 9 inches wide and $\frac{3}{4}$ inch in thickness. **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 329)**

(Continued on page 242)

Pediatric Proctological Table

Developed by Dr. Saul Schapiro of the Jewish Hospital, Brooklyn, the new Schapiro Pediatric Proctological Table is designed to simplify pediatric procto-

logical examination and treatment. The child is placed comfortably in a fixed position for the best possible viewing and ease of instrumentation. The table lifts the abdomen forward and off the table to remove all pressure and cause the viscera to fall forward.

The table is a lightweight unit and can be placed on any flat table or other surface. The sturdy welded tubing frame is finished in baked Silverlux enamel. Sponge rubber cushions are affixed to the frame and covered with durable acid-resistant plastic material. Two adjustable straps are provided to accommodate different sized infants quickly by use of spring snaps. **Shampaine Co., Dept. MH, 1920 S. Jefferson Ave., St. Louis 4, Mo. (Key No. 330)**

Dictaphone Telecord System

Combining the telephone with the Dictaphone dictating machine, the Dictaphone Telecord System provides greater letter and record writing efficiency. It facilitates dictating of medical records and other reports by doctors and department heads and provides readily available dictation facilities throughout the institution. Up to ten telephones can be connected to a centrally located Time-Master dictating machine. Dictators simply pick up the handset and dictate into the centrally located Telecord Time-Master, which can be any distance from the telephone connections.

Use of the system is simple and efficient. A simple stop-start button on the Telecord "phone" gives the dictator control of the Time-Master Dictabelt at all times until released. Handy switches make playback and correction simple. When the Dictabelt is almost fully dictated, a buzzer alerts the dictator to the "approach zone" so that he can finish his dictation before the final signal indicating that the Dictabelt is being changed. The monitor at the central station can see the Dictabelt at a glance, permitting change at efficient intervals. **Dictaphone Corp., Dept. MH, 420 Lexington Ave., New York 17. (Key No. 331)**

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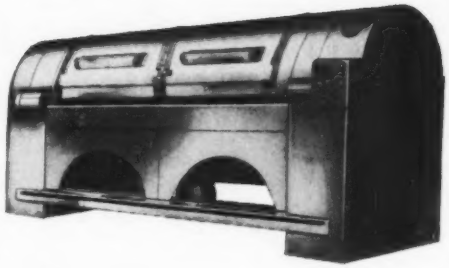
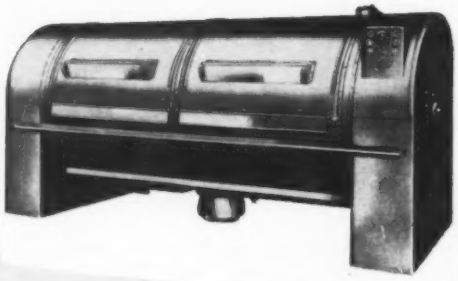
Hoffman Monel Metal "Unloading" and "Standard" Washers

THE "UNLOADING"

Provides more rounds per day by cutting down time formerly needed to "pull" loads. Hydraulic mechanism raises cylinder and shell. Work is deposited into trucks or into basket halves of an unloading extractor. Releases labor for other operations and avoids wear and tear on loads. Single-end drive. Monel metal construction.





THE "STANDARD"

Furnished with open-pocket or horizontal partition. Latter type facilitates "No-Lift" unloading since horizontal partition lines up level with shell door opening. All standard cylinder sizes. Monel metal construction.

YOUR CHOICE OF WASH CYCLE CONTROLS available on "Unloading" and "Standard" Washers. Fully automatic, with central or individual supply stands. Or, semi-automatic with air-actuated control of each operation, once supplies are added.

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The Remington Rand accounting machine as demonstrated at the American Hospital Association Convention.

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Remington Rand accounting machine cuts paper work expenses

Here is the mechanized way to cut office costs that does not require specialized personnel. Accurate, up-to-the-minute bookkeeping and tight control are yours, plus reduced labor costs, improved office morale, and large time savings. The Remington Rand accounting machine has proved a new easy path to maximum efficiency and minimum costs in hospital office management.

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MULTI-PURPOSE MACHINE—This most flexible of all accounting machines effects tremendous savings through handling Accounts Payable with purchase analysis, payrolls, and departmental revenue analysis. End-of-the-month trial balancing is easier because the Remington Rand accounting machine keeps records in perfect agreement and in balance daily.

Free Cost-Cutting Folders—Two free folders—AB-593 and SN-758—show how other hospitals have ended check-out difficulties and obtain departmental analysis as a by-product of patient accounting. Mail the coupon below *today*. Or ask to see this accounting machine at the Remington Rand Business Equipment Center nearest you.

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What's New . . .

Photo-Copy Machine

The new County Recorder Dexigraph is designed for the quick and easy copying of records. Use of the Dexigraph photo-copying method ensures complete accuracy in reproduction. Papers up to 8½ by 14 inches in size are reproduced in full size. Also pages from bound volumes up to 11 by 18 inches can be reproduced on the 11 by 14 inch paper at a 77 per cent reduction in size. With accessory attachments records can be enlarged to 110 per cent of the original. Any kind of record can be copied and up to 200 exposures or 100 fully developed photo-copies can be made per hour. The new Dexigraph is mounted on casters and can be easily moved to the place of use. **Remington Rand Inc., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 332)**

X-Ray Film Identification

Neatly typed identifying data can now be added to radiographs with the new Kodak X-Ray Film Identification Printer, Model B. Designed for darkroom operation, the new printer features automatic timing, uniform exposure, speed and convenience. The new model accommodates a requisition card with the case data to be printed on the radiograph. Finger-tip pressure makes the exposure. Identifying data may be printed on either screen or no-screen film. Model B is sturdily constructed for hard use with a cast metal housing. **Eastman Kodak Co., Dept. MH, Rochester 4, N. Y. (Key No. 333)**

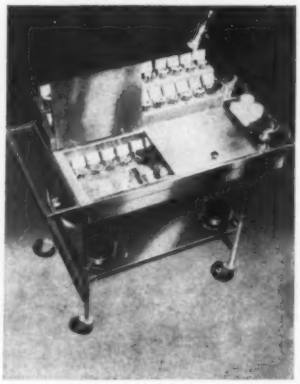
Plastic Dinnerware Cleaner

A new stain remover especially recommended for Melamine molded dinnerware is introduced as Dip-It. It can be used on both plastic and china and will not harm plastic surfaces. Dip-It removes film buildup while bleaching out stain. It is harmless to colors, does not discolor white dinnerware, leaves no odor and prolongs the serviceable life of plasticware by keeping it fresh and new in appearance. The product has been field tested for over two years and has the approval of American Cyanamid Company, basic manufacturers of Melmac plastic. Dip-It can also be used for removing burnt-in stains on Pyrexware and aluminum. **Economics Laboratory, Inc., Dept. MH, Guardian Bldg., St. Paul 1, Minn. (Key No. 334)**

Photo Paper Dispenser

Sensitized photo paper can be safely stored and easily dispensed, one sheet at a time, with the new Ejector Paper Safe. A push of a lever releases the sheet of photo paper when needed. The dispenser is compact and lightproof, durably constructed and finished in black crackle. It is available in sizes to handle 8½ by 11 and 8½ by 14 as well as 5 by 7 and 8 by 10 photo paper. **General Photo Products Co., Inc., Dept. MH, Chatham, N. J. (Key No. 335)**

Medicine Dispenser



Practically a nursing station on wheels, the Meinecke Mobile Medicine Dispenser is a self-contained mobile unit for dispensing routine oral medications and hypodermics to wards and private rooms. The unit provides flexibility, extra large capacity and working space, and is quiet in operation. It is designed to dispense a maximum of 34 medications. All medicine glasses are fitted with Meinecke Combined Metal Covers, Pill Trays and Medicine Card Holders. Two syringe trays, a needle sterilizer and three covered Pyrex jars for cotton balls or pads are conveniently located in a spacious compartment equipped with a divided lid.

The unit is sturdily constructed and equipped with small rubber bumpers to prevent noise when the hinged lids are shut. A swivel-mounted flashlight provides light when medications are dispensed at night without necessitating the turning on of ceiling lights. **Meinecke & Co., Inc., Dept. MH, 225 Varick St., New York 14. (Key No. 336)**

(Continued on page 246)

Aluminum Builders' Hardware

Pressure-cast aluminum is now being used for five items of builders' hardware made by P. & F. Corbin. Included are a door stop, sash fastener, coat and hat hook, bar sash lift and hand rail bracket. The items are strong and durable, though light, and are rustproof and attractively styled. They are economical in cost and are supplied in satin aluminum or ball-burnished brass finish. **P. & F. Corbin Division, The American Hardware Corp., Dept. MH, New Britain, Conn. (Key No. 337)**

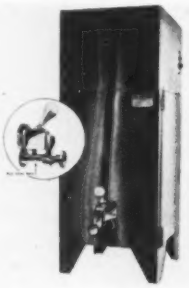
Portable Insulated Containers

The new No. 960 series Portable Insulated Containers for hot or cold beverages are built of stainless steel throughout, completely insulated. They are available in 5 and 10 gallon sizes, with and without a faucet. Liquids are kept at desired temperatures for many hours and are easily served from the Cecilware Containers. Large 11 inch openings make filling and cleaning easy and they are easily handled with the Easy-Grip handles. **Cecil Mfg. Co., Inc., Dept. MH, 206 Canal St., New York 13. (Key No. 338)**

Bulk Milk Dispenser

The new Monitor 20 quart single self-refrigerated stainless steel bulk milk dispenser provides facilities for the sanitary dispensing of bulk milk. As in Monitor dispensers of other sizes, the new unit features the Monitor stainless steel "tube-faucet" which is sealed inside the milk can at the dairy, assuring against the possibility of contamination of the milk in the dispenser.

The dispenser accommodates the standard sized milk can and has ample space below the dispenser faucet for glasses or standard sized milk shake containers. The positive shut-off action prevents milk from dripping and the force of the milk flow is controlled to prevent splash. The dispensers are made



of stainless steel and are self-refrigerated. **Monitor Process Corp., Dept. MH, 192 Bright St., Jersey City 2, N. J. (Key No. 339)**

make your surgical areas safer

with GOLD SEAL NAIRN STATIC-CONDUCTIVE LINOLEUM

The modern hospital's safeguard against headlines like these is Gold Seal Nairn Static-Conductive Linoleum . . . the only linoleum in the world with the unusual property of *dissipating static electricity* which would otherwise present an explosion hazard!

In addition, Static-Conductive Linoleum delivers *durability* and *wear-resistance* . . . *true resilience* . . . a *sanitary, slip-resistant* surface that's *easy to maintain*. AND the famous Gold Seal is your *guarantee of complete satisfaction or your money back!*

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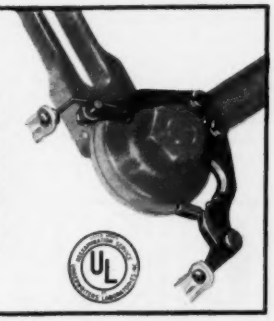
GOLD SEAL NAIRN INLAID LINOLEUM

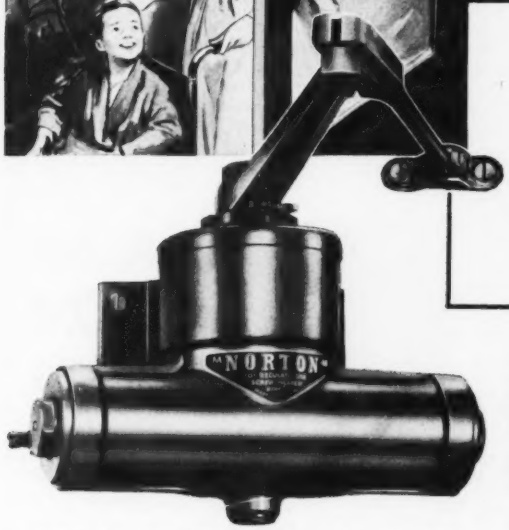
Learn about these 5 important advantages of Norton Door Closers

1. **Parallel arms . . . eliminate need for brackets** . . . give maximum headroom where needed . . . prevent unauthorized tampering.
2. **Rack and Pinion** . . . for uniform, positive action *at every point* to do away with "dead centers."
3. **Permanent mold aluminum shell** . . . engineered to closer tolerances; lighter weight; stops fluid seepage.
4. **Non-gumming, non-freezing hydraulic fluid** . . . lubricates every inside moving part permanently—decreasing wear, increasing life of the parts.
5. **Simple construction** . . . means fewer parts to get out of order—inexpensive to maintain—longer life.

This is the famous Fusible-Link feature:

This special link approved by the Underwriters' Laboratories, fuses quickly at only 160°F. in case of fire . . . automatically letting the door close to stop the frightening spread of flame . . . give time to control the fire. In addition, the use of this arm means reduced insurance rates . . . a substantial yearly savings.





Variety of arms available to fit every need . . . every door

In addition to the regular arm, there is the Norton Hold-Open Arm . . . 90° to 180° Parallel Arm . . . and the Fusible-Link arm described above. For complete information on how Norton can solve your every need write The Norton Door Closer Co., Berrien Springs, Mich.

Only the finest of materials available go into every Norton Door Closer . . . and, skilled craftsmen engineer these materials to the industry's most rigid specifications. Naturally, with quality control and expert instruction at every step . . . from receiving to shipping . . . your Norton Door Closers are precision mechanisms . . . built to last longer under harder service . . . require less maintenance . . . provide you with the long-range economies necessary today.

NORTON

Norton Door Closer Company

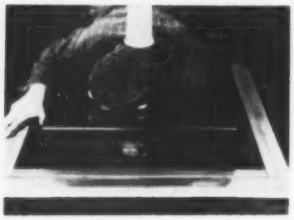
A Division of The Yale & Towne Manufacturing Co.

Norton Door Closers Are Preferred For Hospitals Everywhere

What's New . . .

Sinus-Mastoid Positioning

The True-View Angle Board provides a new low cost type of sinus-mastoid



radiographic positioning device. A mirror indicates precisely whether the angle at which the head is set on the board is the one desired. Any rotation or mal-alignment is seen in the mirror before the radiograph is made. Technicians can duplicate any position with accuracy many times, retakes are eliminated and two views on one 8 by 10 inch film can be taken by shifting the cassette, not the patient. The new True-View Angle Board can be used for both grid and non-grid technics and for both vertical and horizontal technics. It is light in weight and sturdy in construction. **General Electric Co., X-Ray Dept., Dept. MH, 4855 Electric Ave., Milwaukee 14, Wis. (Key No. 340)**

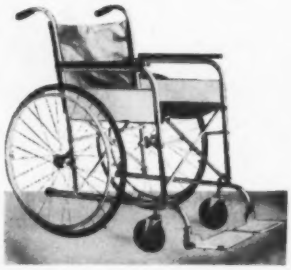
Portion Scale

Advanced design for speed and accuracy in weighing portions in food service is offered in the new Model 3011 Speedweigh Portion Scale. The scale is modern throughout in appearance and construction and offers a choice of either front or side indication. An acrylic plastic dome on the chart housing admits light from both sides and top, eliminating chart shadows and making accurate reading easy. The specially designed charts have red figures on a white background and all charts have indication on both sides. The indicator travels one full inch to each ounce and the scale is easily portable and ready for use anywhere. **Toledo Scale Co., Dept. MH, 1023 Telegraph Rd., Toledo 12, Ohio. (Key No. 341)**

Folding Wheel Chair

The Boulevard 904 Model is a new folding wheel chair designed to include all of the important basic features of folding chairs and to sell at a relatively low price. The seamless steel welded construction of the chassis with double cross braces in front and back provides sturdy support for even heavy patients. The chair has steel skirt or coat guards, retractable, two-piece, adjustable aluminum foot rests, and walnut finished, birch armrests. The chassis is finished in the new Gendron "Silver Brite" plating that is attractive in appearance and durable.

The tangent spoke 24 inch wheels have steel hand rims and roll on ball bearings in sealed hubs. The five inch front casters are rubber tired and operate in ball bearing swivels. The push handles are equipped with rubber hand grips and a rear, foot-leverage extension facilitates lifting over curbs. The flexible seat and back are covered with washable, brown Naugahyde. The chair is 25½ inches wide overall and folds to approximately 10½ inches for easy storage. **Gendron Wheel Co., Dept. MH, Perrysburg, Ohio. (Key No. 342)**



(Continued on page 250)

PALMOLIVE SOAP

In the familiar green wrapper—is known and enjoyed in millions of homes throughout America. Provides abundant lather and meets highest hospital standards for purity. Available in ½, ¾, 1 and 2-oz. cakes.

CASHMERE BOUQUET

The aristocrat of fine toilet soaps. A big favorite in private pavilions because women like the delicate perfume and rich, creamy lather of this long-lasting luxury soap. Available in ½, ¾, 1 and 1¼-oz. cakes.

Well-Known C.P.P. Soaps Add A "Personal Touch" To Hospital Service!

Hard as you try, it's difficult to provide a homelike atmosphere in a hospital. But there's one thing you can do that patients recognize and appreciate. And that is: give them the same soaps they use at home... Palmolive or Cashmere Bouquet. These well-known Colgate-Palmolive-Peet soaps —so popular at home—are ideal for hospital use. See your C.P.P. representative, or write for prices—today!

COLGATE'S BEAUTY WHITE SOAP

—2oz., HARD MILLED, mildly perfumed, abundant lather. Long lasting, kind to skin. Economical, too.

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New 1952 Handy Soap Buying Guide. Tells you the right soap for every purpose. Get a copy from your C.P.P. representative, or write now to our Industrial Department.

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HUCK AND TURKISH TOWELS; BATH MATS (*both plain and name woven*) · CABINET TOWELING · FLANNELETTES DIAPERS · DAMASK TABLE TOPS AND NAPKINS CORDED NAPKINS · DUNFAST ALL-PURPOSE FABRICS

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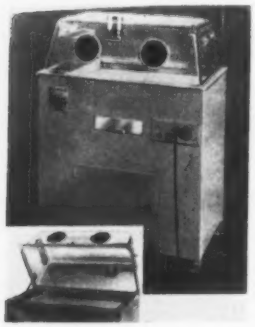
BRANCH OFFICES: BOSTON · CHICAGO · DALLAS · DETROIT · GRIFFIN · LOS ANGELES · PHILADELPHIA · ST. LOUIS · SAN FRANCISCO

What's New . . .

Redesigned Infantair



Four separate functions are served with the newly designed Infantair. It serves as a baby incubator with circulating humidity and temperature control, as an infant oxygen tent with cooling system, as an isolation cabinet with large spacious storage, and as a surgical bed large enough to accommodate a six month old patient, with Trendelenburg and other conventional adjustments.

The new improved Perma-Vue Hood is constructed of heavy duty plexiglas and was developed at the request of pediatricians and obstetricians as a combination service to accommodate the requirements for oxygen, heat, isolation or surgery. The one piece hood is easy to sanitize as it is unaffected by hospital germicides or washings. The hood fits snugly over the Infantair cabinet and can be readily opened for access to patient. The top is firmly hinged and equipped with a safety lock to tilt to open position. The hood is fitted with flexible isolation sleeves as a further safety method to prevent disturbance of the controlled atmosphere within. The Perma-Vue Hood is interchangeable with the disposable canopy top. **Continental Hospital Service, Dept. MH, 18636 Detroit Ave., Cleveland 7, Ohio. (Key No. 343)**

Food Waste Disposer

A self contained unit for the disposal of all types of cooked and uncooked food waste is offered in the new Salvajor WasteXit, Model MA2 Food Waste Disposer. The unit bolts to the floor and drain connection can be made on either side. It consists of the grinder, feed chute, safety feed door, water control mechanism and magnetic starter. It is adaptable to any table 35 inches high. Waste is discharged as a flowing liquid and the unit has a capacity for disposal of 1500 pounds of waste per hour. **The Salvajor Co., Dept. MH, 118 Southwest Blvd., Kansas City 8, Mo. (Key No. 344)**

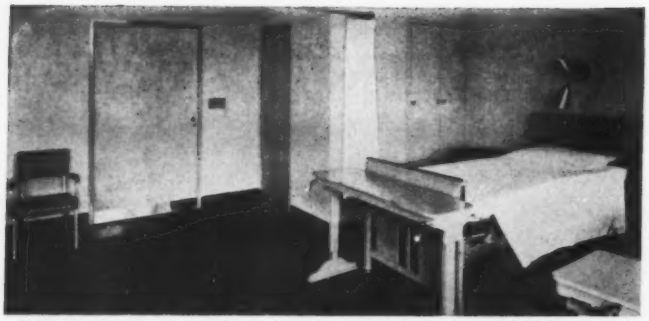
Four Way Door Catch

The new G-J 21A Four Way Catch pulls and holds the door closed, It can be mortised or surface mounted for use on closet doors, wardrobe doors, grills and heavy openings that are hinged. Upon engaging, the door is pulled closed and held under constant tension by two steel balls with adjustable spring pressure.

Body and engaging stud are made of extruded bronze. As the name indicates, the catch will hold from four ways and is built with exacting workmanship throughout for efficient operation. The G-J 22 is a two way catch

similarly operated and applied. **Glynn-Johnson Corp., Dept. MH, 4422 N. Ravenswood Ave., Chicago 40. (Key No. 345)**

(Continued on page 254)



Weldwood "Stay-Strate" flush doors with fire retardant panels of matched birch in natural finish in one of the four-bed rooms of Greenwich Hospital, Greenwich, Conn.

Some of the

500

Weldwood X-ray door in the X-ray Division of Greenwich Hospital. More than 500 Weldwood "Stay-Strate" doors are used throughout this 180-bed hospital. Architects: Skidmore, Owings and Merrill.

"Quiet, Please" Doors

in Greenwich Hospital

In Greenwich Hospital, Greenwich, Conn., *every* room is equipped with doors that seem to say, "Quiet, please." There are more than 500 of them. Each bears the Weldwood® label. They are birch doors, with matched veneer panels, and good-looking, as you can see.

Even more important – they are Weldwood "Stay-Strate" doors made with the same mineral core material used in Weldwood Fire Doors.

That helps explain why Stay-Strate doors have good fire resistance, and remarkably good sound-reduction properties. Properly hung, the average sound transmission loss is 31 decibels.

Add to these advantages the maximum degree of dimensional stability displayed by Stay-Strate doors. That helps you understand why Stay-Strate doors are so highly regarded by architects and builders of offices and hotels as well as hospitals and institutions.

Stay-Strate doors are so completely dimensionally stable that each one carries a "life of installation" guarantee against warping.

SPECIFICATIONS

Face Veneers: Face veneers are standard thickness, laid with grain at right angles to the grain of the cross bands. *Standard thickness:* 1/28" – sliced or rotary cut, domestic or foreign woods.

Core: The core is made of a mineral composition material of 20 lb. per cubic foot nomical density, having unusual dimensional stability, incombustibility, structural strength and vermin- and decay-proof characteristics. Each core is made of three or more pieces securely bonded together by the high frequency process.

Cross Bands: Cross bands are thoroughly kiln-dried hardwood, 1/16" thick, extending the full width of the door and laid with the grain at right angles to the face veneers.

Rails: Top and bottom rails are thoroughly kiln-dried hardwood, total width 4-3/8", built up of stock securely glued together.

Side Edge Bands: Side edge bands are thoroughly kiln-dried hardwood, total width 1-3/8", built up of two (2) pieces of stock securely glued together. Exposed bands are one piece the full length of the door and of same wood as face veneer.

Adhesive: Crossbandings and faces are laminated to core with 100% waterproof TEGO film phenolic glue, by hot plate process, providing a door especially adapted for exterior use.

Lock Block: A lock block, 3-13/16" wide, 35-5/8" long, is provided. Inside edge of lock block is not less than 5-3/16" from outer edge of door. Minimum distance from bottom of lock block to bottom of door is 22-3/16". Lock block is on one (1) side of door only. Each door is stamped, indicating location of lock block.

Sanding: Both faces are smoothly belt sanded before leaving the factory, providing perfect surfaces for paint or natural finishes.

Profit: All doors are trimmed square and factory prefit to standard book sizes.

Sizes: Doors are available in a wide range of sizes in 1-3/4" stock thickness. Also available in 2-1/4" and 1-3/8" thicknesses.

Light and Louvre Openings: Where specified, doors are provided by the door manufacturer with light and louvre openings in accordance with the WELDWOOD Standard Details which include circular, rectangular and divided lights. Glass beads for light openings are provided tacked in loose. All glazing and installation of louvres shall be done in the field.

Don't overlook *Weldwood Partition Panels*
These beautiful wood-faced partition panels are made with the same incombustible mineral core used in the famous Weldwood Fire Door. Available with a variety of wood faces and readily adapted to low-railing, 7-foot and full ceiling height partitions...either permanent or movable. Specify them for offices, schools, hospitals and other institutions.

WELDWOOD® FLUSH DOORS

Manufactured and distributed by

UNITED STATES PLYWOOD CORPORATION

World's Largest Plywood Organization

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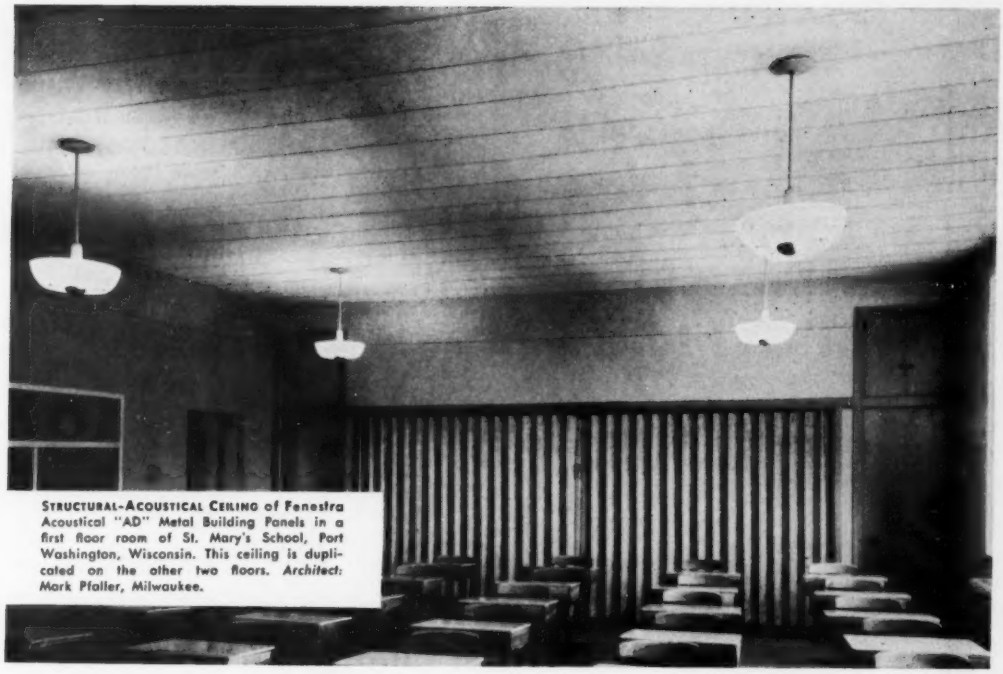
Dealers Everywhere



STRUCTURAL-ACOUSTICAL CEILING of Fenestra Acoustical "AD" Metal Building Panels in a first floor room of St. Mary's School, Port Washington, Wisconsin. This ceiling is duplicated on the other two floors. *Architect:* Mark Pfaller, Milwaukee.

Quiet doesn't have to be an "*extra*"!

Now acoustical treatment can be an integral part of your *structural* building. Nothing to *apply*! No extra *work* to pay for!

Fenestra* Acoustical "AD" Panels form ceiling, silencer and sub-floor . . . all in one *economical* package.

An "AD" Panel is a strong metal box beam. The flat, smooth, top surface forms the sub-floor or roof deck. The flat, smooth, perforated undersurface forms the ceiling. In the open space between is glass fiber sound insulation. Installation of interlocking panels is simple and quick!

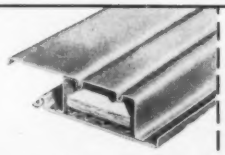
Beautiful, rugged, and rigid, this new kind of acoustical ceiling can be washed or painted without hurting its 80% N.R.C. acoustical efficiency.

And perhaps even more important, it is *noncombustible!*

Get the whole money-saving story . . . write Detroit Steel Products Company, Dept. MH-10, 2258 East Grand Blvd., Detroit 11, Michigan. *●

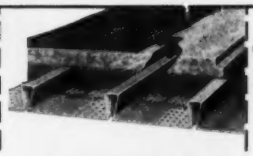
Fenestra METAL BUILDING PANELS

...engineered to cut the waste out of building

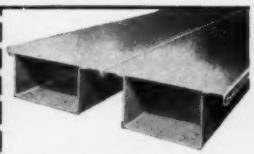


Acoustical "AD" Panels for ceiling-silencer-roof. Width 16". Depth up to 7½".

"C" Insulated Wall Panels. Width 16". Depth is 3". Steel or Aluminum.



Acoustical Holorib for acoustical-structural roof. Width 18". Depth 1½".

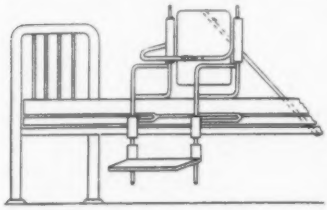


"D" Panels for floors, roofs, ceilings. Standard width 16". Depth 1½" to 7½".

What's New . . .

Bed-Chair

Post-operative, maternity, orthopedic, chronic or other patients who are benefited by sitting up on the edge of the bed, will be helped by the new Rocke "Sit-Up Bed Chair." It is quickly assembled around the sitting patient without lifting or moving the patient into the chair. Side pieces are set up after the patient is in a sitting position on the edge of the bed, supports go under the mattress to hold the chair in place and the back slides on over the uprights. An adjustable height footrest adds to the comfort. There is a safety strap to prevent the patient from falling from any cause and a retaining strap anchors the chair on the far side of the bed.



Firm support is given to the patient in sitting up and the feet rest on the foot rest which is adjustable to comfortable height. The chair permits patients to have the comfort and benefit of a sitting posture, with the feet lowered, without getting out of bed. **Wm. Rocke Co., Inc., Dept. MH, P. O. Box 623, Bloomington, Ill. (Key No. 346)**

Stop-Clock

The Precision "Secron" second stop-clock is designed to have the accuracy of a stopwatch but the visibility of a household clock. This laboratory timer has a 36 hour movement controlled by two buttons on top, green for start and red for stop. A clear black on white dial is marked in seconds and a large sweep hand permits estimations to half a second. Total time elapsed up to 60 minutes is registered by a smaller integrating hand. The stop-clock is sturdy and inexpensive. **Precision Scientific Co., Dept. MH, 3737 W. Cortland St., Chicago 47. (Key No. 347)**

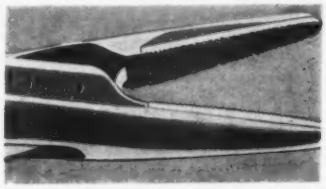
Wall Covering

An inexpensive wall covering simulating ceramic tile in plain and marbleized effects is offered in Trenwall. It has a special new enamel finish which is alkali-resistant, super-hard and has a high gloss that is durable and easy to clean. The especially processed Neofelt backing makes it flexible and easy to handle. **Sloane-Blabon Corp., Dept. MH, 295 Fifth Ave., New York 16. (Key No. 348)**

Diamond Jaw Needle Holder

The teeth in the new "Ochsner Diamond Jaw" Needle Holder are made of a substance which is so hard that it has to be cut with diamond cutters. As a result, the teeth retain their sharpness for a long period of time and thus hold the needle firmly, preventing it from turning. Because of the hardness of the teeth, the jaw is relatively narrow.

Developed by Dr. Alton Ochsner of Tulane University, New Orleans, and Leonard R. Snowden, the Ochsner Diamond Jaw Needle Holder provides efficient operation in an instrument designed to give long service. **Snowden Instrument Co., Dept. MH, P. O. Box 186, Los Gatos, Calif. (Key No. 349)**



(Continued on page 258)

What's Your Hospital Problem?

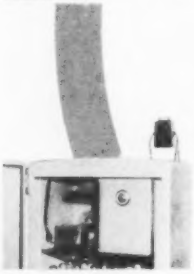
Carbonated drink dispenser that automatically measures the proportion of syrup to carbonated water.

Diet-therm. A special diet tray accessory that rides on top of any average conveyor. Diet-therm is provided with its own temperature control. 54 different combinations of pans.

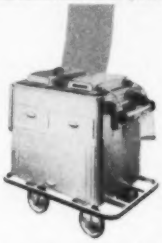
It is traditional in the hospital field to ask Ideal to help solve many problems not covered by any existing standard hospital equipment units.

The specialized field of Ideal is the automatic operation and control of temperatures in utensils and apparatus designed for specific purposes. These requirements often go far afield from Ideal's traditional food conveyor line. Here we show you a few custom-built special units created for hospitals seeking more efficiency and economy in meeting recurring special needs.

Ideal engineers will gladly study your problem and make recommendations no matter what phase of hospital service is involved. This service entails no charge nor any obligation.



Blood Bank Guard. An alarm device that automatically gives audible and visible signals when the blood reaches 50 degrees of temperature or sinks to 40 degrees.



Compact special diet food conveyor for limited volume special diet service.

Bassinet basket that carries all necessary items for complete individual care of infant, avoiding mixed use. One hangs on each bassinet.

Standard Ideal Food Conveyors for general hospital use are available in many models.

Terminal Sterilizer. The amazing new Ideal unit for automatic sterilization of bottles, nipples and infant formulae.

Ideal Hot Pack Heater. 2 sizes. Holds heat 30 minutes after disconnection from current. Roll it to the bedside.

WRITE FOR CATALOG

Ideal

HOSPITAL EQUIPMENT

Found in Foremost Hospitals

MADE ONLY BY THE Swartzbaugh MANUFACTURING COMPANY

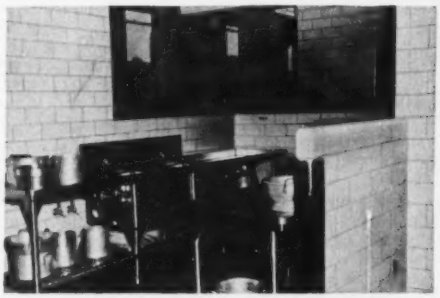
ESTABLISHED IN 1884 — TOLEDO 6, OHIO

HOSPITAL INDUSTRIES ASSOCIATION HIA

SPACE No. 124
AMERICAN DIETETIC ASSOCIATION CONVENTION
MINNEAPOLIS, MINNESOTA
OCTOBER 21-24 INC.

SPACE No. 729-733
AMERICAN HOSPITAL ASSOCIATION CONVENTION
PHILADELPHIA, PENNSYLVANIA
SEPTEMBER 15-18 INC.

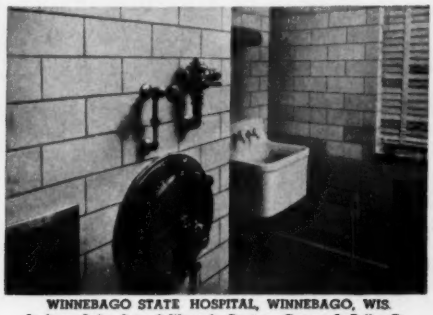
Distributed by the Colson Corporation, Elyria, Ohio; The Colson Equipment and Supply Co., Los Angeles, and San Francisco. In Canada: Canadian Fairbanks-Morse Company.



BETH-ISRAEL HOSPITAL ADDITION, BOSTON, MASS.
Archts.—Curtis and Riley. Contrs.—Volpe Constr. Co.

ST. VINCENT'S HOSPITAL, TOLEDO, OHIO
Archts.—Maguolo & Quick. Contrs. A. Bentley & Sons

LLOYD ST. JOSEPH HOSPITAL, MENOMINEE, MICH.
Arch.—Harry W. Gjelsteen.
Contrs. Prokach Constr. Co.



WINNEBAGO STATE HOSPITAL, WINNEBAGO, WIS.
Archts.—Auler, Irion & Wertsch. Contrs.—George A. Fuller Co.

Hospital interior views above show use of NATCO Ceramic Glazed Vitrilile for walls

NATCO
QUALITY CLAY PRODUCTS SINCE 1889

IN HOSPITALS • EVERYWHERE

NATCO Ceramic Glazed Color Engineered VITRITILE

In all of the hospitals pictured above, Natco Ceramic Glazed, Color Engineered Vitritile was selected for interior walls and partitions for color and finish, because it solved such definite hospital needs and problems as good visibility, relief from eye strain, fatigue, convalescence, etc.

In addition to being the right colors for hospital interiors, walls and partitions of Natco Ceramic Glazed Vitritile will stand up under hard usage, give the utmost in sanitation, are proof against rodents, vermin and bacteria — are easily cleaned and kept clean with ordinary soap and water.

Designed for either modular or conventional design, Natco Ceramic Glazed Vitritile with its complete line of shapes and coordinated fittings is completely adaptable to desirable and efficient layout design, with a minimum amount of cutting and fitting.

Write for additional information on Natco Ceramic Glazed Vitritile, also for literature describing other Natco Structural Clay Products for use in **every type of building construction.**

THE PRODUCERS' COUNCIL

FTI Member of Facing Tile Institute

NATIONAL FIREPROOFING CORPORATION

GENERAL OFFICES: 327 FIFTH AVENUE • PITTSBURGH 22, PA.

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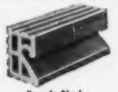
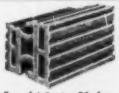
"The Quality Line Since 1889"

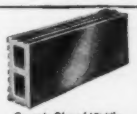


Roggle Blocks
Prevent Water Seepage
4" x 5⅓" x 12" Nom. Size



Speed-A-Backer Tile for
Backing Brick Faced Walls
12" long Varying Heights

Ceramic, Clear
Glazed Vitrilile 5⅓" x 12"
Nom. Face Size



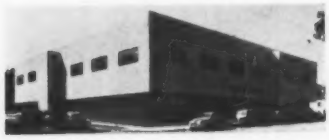
Ceramic Glazed Vitrilile
8" x 16" Nom. Face Size

Non-Loadbearing Tile, Scored
and Unscored, 12" x 12" Face
In Standard Wall Thicknesses

Buff Unglazed, Manganese
Spot, Salt Glazed, Red
Textured Dri-Speedwall Tile,
5⅓" x 12" Nom. Face Size

What's New . . .

Thermo-Sash



A fully-insulated aluminum window frame is offered in Thermo-Sash. This new aluminum insulating sash has been tested in actual installations indicating that the aluminum alloy construction eliminates condensation and frost on the interior metal surfaces at normal room temperatures and humidity even when outside temperatures drop below 20 degrees below zero. The new sash matches in insulating qualities the performance of the double-paned insulating glass and the conventional brick or frame wall, thus saving heat in winter and improving air conditioning. The structural strength of the attractive aluminum frame enables the new insulating sash to meet all of the setting specifications for Thermopane, product of Libbey-Owens-Ford Glass Co., according to the manufacturer. The new sash was designed especially for use in hospitals, laboratories and similar installations. **Kesko Products, Inc., Dept. MH, Bristol, Ind. (Key No. 350)**

Mimeograph Stencil Sheet

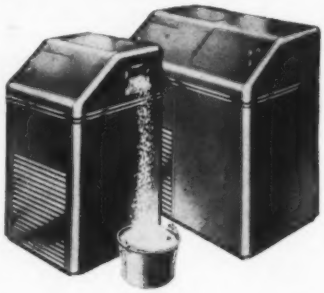
Available in four sizes, the new A. B. Dick orange colored multi-purpose mimeograph stencil sheet assembly can be had in legal and letter sizes, with or without satin finish film-topping. They give top quality copies with long runs on the mimeograph with quick drying inks such as Dick's Contac-Dri and exceptionally long runs with more commonly used oil base inks. The orange color of the stencil provides high visibility while the stencil is in the typewriter and when it is used on the Mimeoscope illuminated drawing board.

The assembly features a new black cushion sheet. The glossy jet black plastic coating eliminates the need for burnishing errors, thus simplifying the making of corrections. The reverse side coating produces a proof copy on the backing sheet for easy proof reading. The new stencils are designed for use in the offset process when used as negatives for producing photographic plates. **A. B. Dick Co., Dept. MH, 5700 W. Touhy Ave., Chicago 31. (Key No. 351)**

Automatic Ice Makers

Already flaked ice can now be made automatically in four new low-priced ice makers recently introduced. Known as the Scotsman Super-Flakers, the new automatic ice flakers are available in capacities of 350 to 430 or 750 to 900 pounds of flaked ice daily. Each size is available in the completely automatic storage-type unit or the continuous-flow type unit. The storage-type unit operates automatically, keeping the heavily-insulated stainless steel storage bin full regardless of use.

The new units have a minimum of moving parts and nothing to get out of adjustment. They are the result of research and rigid field testing. They are easily installed and are 40 inches high for



back of counter use. **American Gas Machine Co., Dept. MH, 505 Front St., Albert Lea, Minn. (Key No. 352)**

(Continued on page 262)

MORE DOCTORS ADVISE IVORY THAN ANY OTHER SOAP!

No other brand of soap has ever won the widespread medical and hospital approval that Ivory Soap enjoys. The reasons for this are logical.

Where skin care is unusually important—as it is in the hospital—Ivory's superb purity and mildness are outstandingly desirable qualities. Ivory's fresh, clean-smelling lather is wonderfully pleasant to sensitive skins.

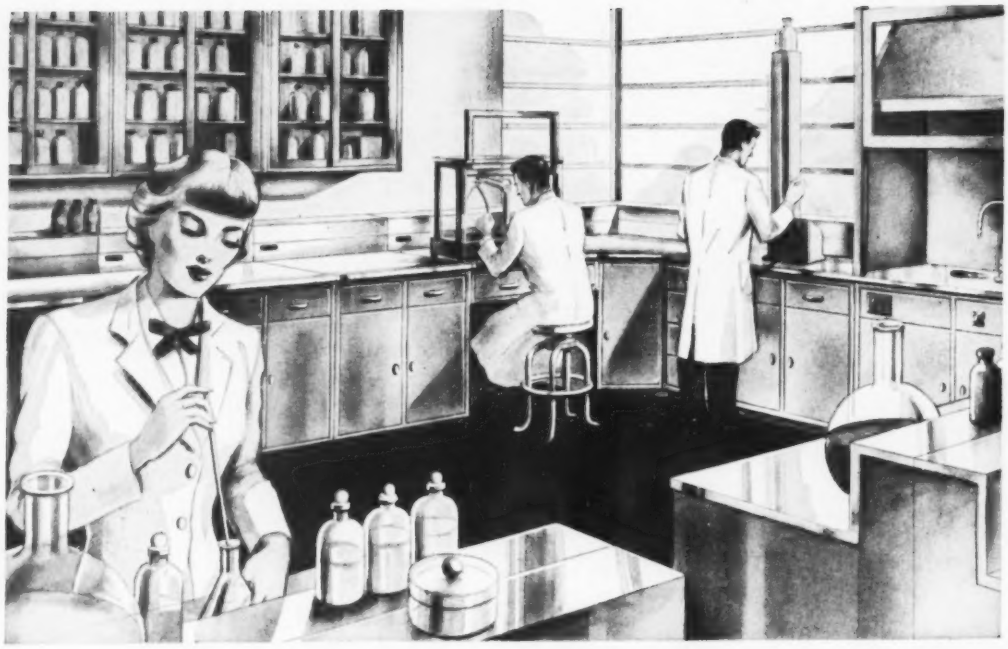
For well over half a century, Ivory has been a valued "assistant" in countless hospitals. You will find Ivory eminently qualified to serve *your* institution.

Ivory Soap

99 44/100% pure — it floats

Pure, mild, rich lathering Ivory Soap is available for hospital use in the popular unwrapped 3-ounce size (packed weight) as well as in smaller sizes—wrapped or unwrapped.

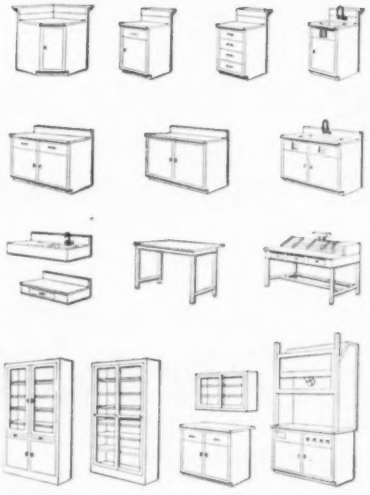
Procter & Gamble CINCINNATI, OHIO



PLANNING A LABORATORY?—*Let Aloe Help You*

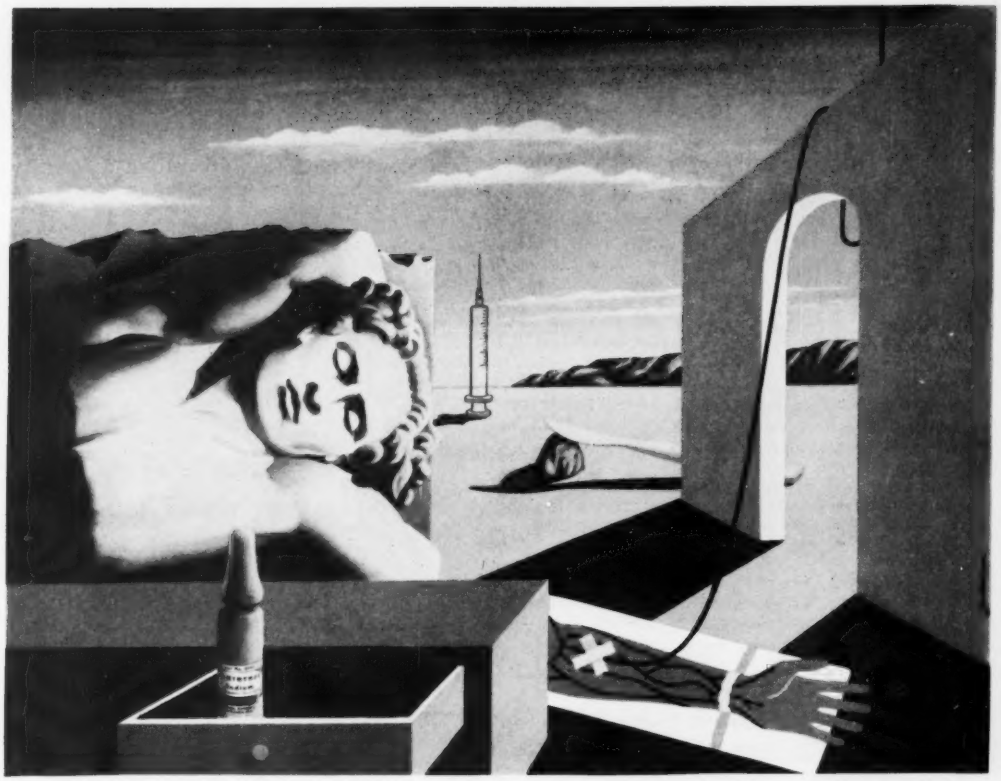
The easiest and most economical way to install basic cabinets, casework, and fixtures in your new laboratory

Moduline has made planning and installation of laboratory fixed equipment an easy and comparatively low-cost problem. It consists of a wide choice of standard drawer units, cabinets, sinks, work tables, etc., designed to make up a complete layout of basic equipment for installations of any size. Unlike custom-built installations, which do not lend themselves to future expansion or modification, Moduline may be expanded, rearranged or moved to another location. Moduline units are available 24, 35, or 47 inches wide, making it possible to plan large or small installations without expensive preliminary planning and technical assistance. Line drawings at right show representative units which may be quickly arranged to form continuous, interrupted or island-type installations of any desired size. Sink units are available with basins of stainless steel or Alberene stone. Tops and splash-backs of all units are of stainless steel; body structures are of electrically welded steel. Our planning department is prepared to submit suggested room layouts and cost estimates for your Moduline equipment. Please write for descriptive brochure.



Above is shown representative units of Moduline sectional laboratory cabinets and casework

A. S. ALOE COMPANY *AND SUBSIDIARIES* — 1831 Olive Street, St. Louis 3, Missouri
LOS ANGELES • NEW ORLEANS • KANSAS CITY • MINNEAPOLIS • ATLANTA AND WASHINGTON, D. C.

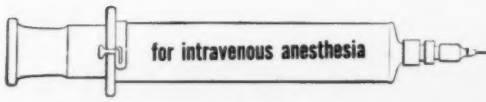


"Actually, it has not been so much a case of PENTOTHAL Sodium's supplanting other anesthetic agents and methods as it has been of complementing and supplementing them to the mutual advantage of one another."

Adams, R. Charles (1951), Intravenous Administration of Pentothal Sodium in Combination with Other Anesthetic Agents and Methods, J. Missouri Med. Assn., August.

IN minor and major surgery, for induction or induction and maintenance, *alone or in combination* with other anesthetics, PENTOTHAL Sodium continues to grow in popularity in operating rooms throughout the civilized world. Not without reason:

Eighteen years of experience, nearly 1900 published reports have shown that intravenous anesthesia with PENTOTHAL means a smooth, easy induction, generally without anxiety. And that deeper anesthesia may be had in a moment, as needed. Recovery is short, pleasant and usually without nausea. No bulky frightening equipment is needed. The fire and explosion hazard is eliminated. And, as it says above, this ultra-short-acting barbiturate complements and supplements other agents to "the mutual advantage of one another." Abbott



PENTOTHAL® Sodium

(STERILE THIOPENTAL SODIUM, ABBOTT)

What's New . . .

Beverage Server

Cold water can be always available at the patient's bedside with the new Universal VB8392 Individual Beverage Server. This larger capacity insulated server holds four cups of liquid and can be used for ice water or other beverages as well as for hot drinks either as a part of the meal or between meals.

The cover on the new server is also insulated to increase the server's thermal properties. Two projections on the lip of the filler hold the cover firmly while pouring. The server is similar to the smaller two cup Universal VB8290. The finger grip of the new cover has been recessed and reshaped for more ease in handling and the new model has increased diameter although it is the same height as the earlier model. The server has a chrome-plated shell which is easily kept clean, a renewable molded brown plastic liner, is easily sterilized and is constructed for hard usage. **Landers, Frary & Clark, Dept. MH, New Britain, Conn. (Key No. 353)**

Anti-Slip Floor Finish

Grip-Kote is an anti-slip floor treatment containing enough carnauba wax for buffing but eliminating the excessive pliant qualities of wax. It dries quickly to a high, hard gloss and is non-tacky, water resistant and long wearing. It can be used on all floors but is especially adapted to asphalt tile. **Continental Car-Na-Var Corp., Dept. MH, Brazil, Ind. (Key No. 354)**

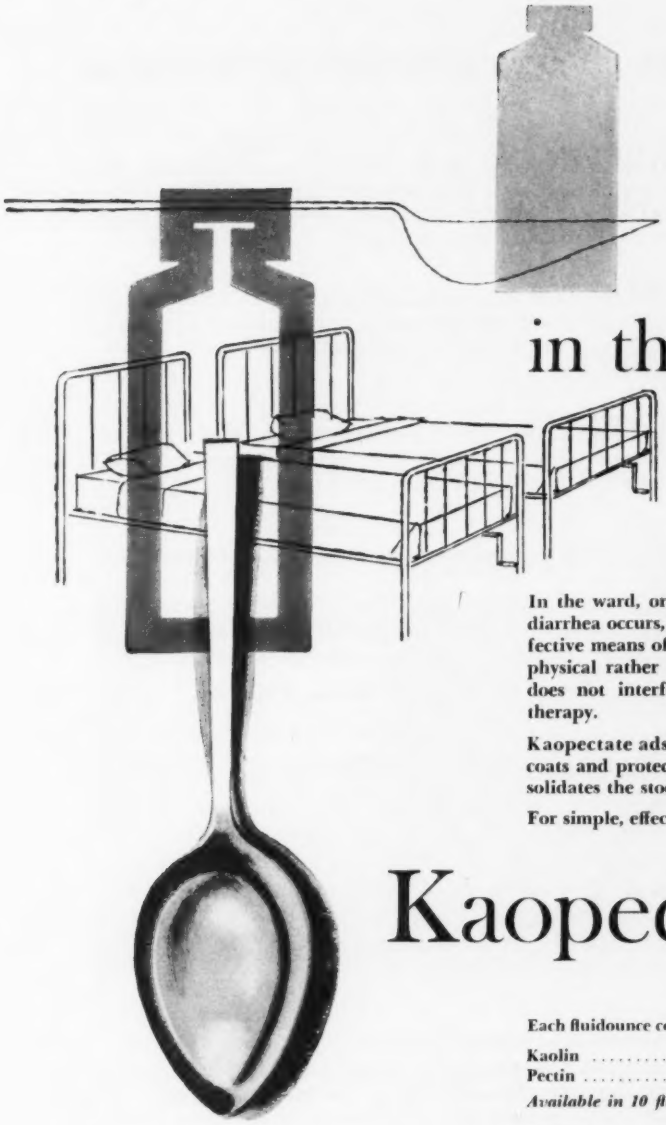
Modular Multi-Vent

A new type of ceiling air diffusing panel, the Modular Multi-Vent, is designed for heating, cooling and ventilating systems using either duct or plenum air supply. The new diffuser is designed to reduce the cost of installing an air distribution system in acoustical metal pan ceilings. It can be incorporated into metal pan ceilings at minimum cost, delivers conditioned air at low velocities and accomplishes over-all air distribution by pressure displacement. Its operation permits locating the panels anywhere in the ceiling to meet load conditions. The panels are completely concealed by standard perforated metal ceiling pans and do not interfere with design details.

The Modular Multi-Vent is a simple assembly which is quickly and easily installed. It is therefore readily and economically incorporated into existing acoustical metal pan ceilings as well as

into new buildings. **The Multi-Vent Division, The Pyle-National Co., Dept. MH, 1334 N. Kostner Ave., Chicago 51. (Key No. 355)**

(Continued on page 266)



in the ward

In the ward, or any place where common diarrhea occurs, Kaopectate provides an effective means of control. Since its action is physical rather than chemical, Kaopectate does not interfere with concurrent drug therapy.

Kaopectate adsorbs toxins and bacteria, coats and protects mucosal tissue, and consolidates the stool.

For simple, effective control of diarrhea . . .

Kaopectate*

Each fluidounce contains:

Kaolin	**90 grs.**
Pectin	**2 grs.**

Available in 10 fluidounce bottles.

Dosage:

Adults — 2 or more tablespoonfuls after each bowel movement, or as indicated.

Children — 1 or more teaspoonfuls according to age.

* Trademark, Reg. U. S. Pat. Off.

a product of **Upjohn Research** *for medicine . . . produced with care . . . designed for health*

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN

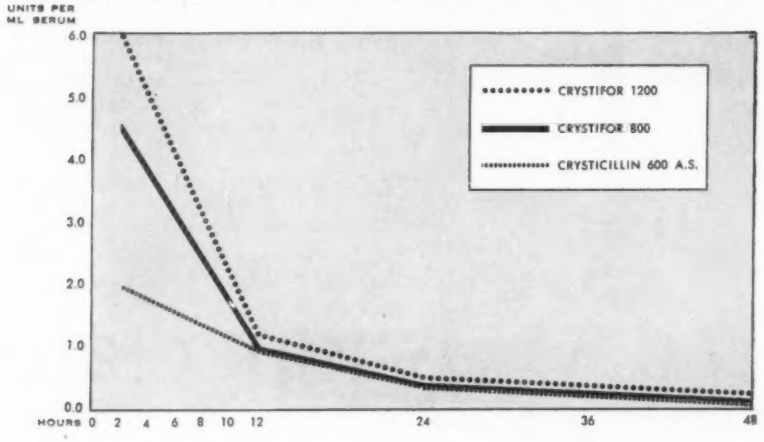
new *high potency* penicillin preparations

CRYSTICILLIN 600 A.S. Squibb Procaine Penicillin G, 600,000 units per 1.2 cc. *in aqueous suspension* ready to inject. Stable for 1 year if stored below 15 C. *10 dose silicone-coated vials (12 cc., 6,000,000 units), 1 dose 'Unimatic' disposable syringe.*

CRYSTIFOR 800 Squibb Procaine Penicillin G, 600,000 units, plus Potassium Penicillin G, 200,000 units, for aqueous injection. Injection volume 1.1 cc. *1 and 5 dose silicone-coated vials (800,000 and 4,000,000 units).*

CRYSTIFOR 1200 Squibb Procaine Penicillin G, 900,000 units, plus Potassium Penicillin G, 300,000 units, for aqueous injection. Injection volume 1.75 cc. *1 dose silicone-coated vials (1,200,000 units).*

SCHEMATIC SERUM CONCENTRATIONS OF PENICILLIN



New antibiotic combinations also available:

DICRYSTICIN FORTIS, Squibb Procaine Penicillin G, 300,000 units, plus Potassium Penicillin G, 100,000 units, plus 1 Gm. Dihydrostreptomycin Sulfate, for Aqueous Injection. 1 dose vial. (Dicrysticin Fortis differs from Dicrysticin in that it contains twice the amount of dihydrostreptomycin – 1 Gm. instead of 0.5 Gm.).

DISTRYCILLIN A.S. Squibb Procaine Penicillin G, 400,000 units, plus 0.5 Gm. Dihydrostreptomycin Sulfate, in Aqueous Suspension. Stable for 1 year if stored below 15 C. Supplied in 1 and 5 dose vials (2 and 10 cc.).

SQUIBB A LEADER IN THE RESEARCH AND MANUFACTURE OF PENICILLIN AND STREPTOMYCIN

What's New . . .

Incinerator

The new Winnen Commercial Incinerator for the quick and efficient disposition of refuse without hauling, consumes up to 400 pounds per hour of wet or dry refuse of all kinds. A smaller model handling 100 pounds per hour is also available. Combustion is complete and the large sized C-20 can be installed without brick work or masonry in a relatively short time. Practically all smoke and odors are eliminated through forced draft, a special ventilating system and secondary combustion. Twin burners using natural, manufactured, bottled gas or oil fuel provide a hot, intense flame for quick disposition of refuse and the units are designed for installation indoors or out. The unit is equipped with safety devices. **The Winnen Incinerator Co., Dept. MH, 932 Broadway, Bedford, Ohio. (Key No. 356)**

Rubber-Base Outdoor Paint

The new Tropical Cementkote is a rubber-base paint for outside masonry application. Based on synthetic rubber resin, the new product can be applied to cement, cinder block, stucco, brick and stone and provides exceptional resistance to moisture penetration and alkali reaction. Flaking and cracking of masonry caused by freezing and thawing are also reduced by the moisture-sealing action of Cementkote.

No priming or special preparation is needed to paint new construction and no waiting for curing or seasoning is required. Cementkote has a mild, controlled chalking effect and rain will wash off dirt, dust and soot, leaving a fresh, clean appearance. **The Tropical Paint & Oil Co., Dept. MH, 1246 W. 70th St., Cleveland 2, Ohio. (Key No. 357)**

Alcohol Dispenser

The new Levernier Airlift Alcohol Dispenser is wall panel mounted and foot pedal operated. The mounting panel is 23 inches long, 3⅛ inches wide and ¼ inch thick with three holes drilled for mounting to the wall. The dispenser is equipped with a half gallon jar at the top and a one gallon receiving jug at the bottom of the tray. The pump is all stainless steel and the non-corrosive stainless steel tray is in a large oval shape, eight inches deep. The solution may be

filtered for re-use. **The Levernier Laboratories, Inc., Dept. MH, Syracuse, Ind. (Key No. 358)**

(Continued on page 270)

Luxury!
Economy!
Therapeutic Value!

The beautiful Mather Home for Aged Ladies
...in Evanston, Illinois

...Why the MATHER HOME uses GOODALL FABRICS

The main dining room is decorated with elegant draperies of Goodall Fabrics "Print & Imprint." These draperies hang in rich, heavy folds...ward off wrinkles, shed dust easier, help soften noises.

This typical Mather Home living room features draperies of Goodall Fabrics wrinkle-resistant "Grapevine," and enduring upholstery of "Grandee," and "Beekman," that adds home-like beauty and comfort.

Goodall Fabrics for hospitals and allied institutions are made to meet special needs. The therapeutic value of their colors, their luxurious textures and spirit-lifting designs, their noise-muffling quality help create an atmosphere of quiet charm. And Goodall Fabrics are economical because they are *Blended-to-Perform!* That's why modern hospitals count on Goodall Fabrics to keep their beauty and shape through countless washings and cleanings . . . stay color-bright . . . wear longer.

Interiors by Hospital Furniture, Inc.

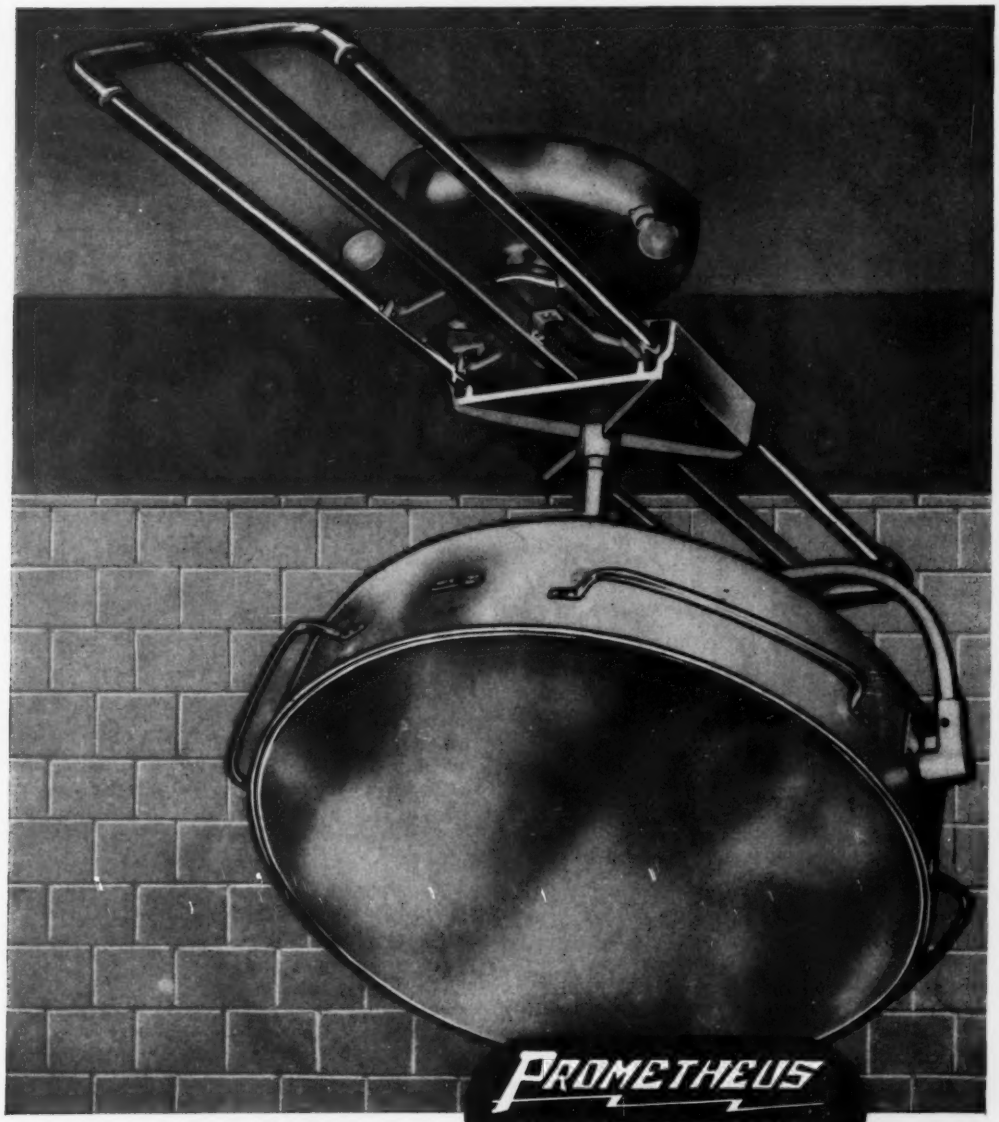
Hospitals Everywhere Get
Longer Service, Lower Maintenance, Richer Beauty
With Goodall's Specialized Hospital Fabrics For:
DRAPERIES • UPHOLSTERY • SLIPCOVERS
BEDSPREADS • CUBICLES • CASEMENTS

Goodall Fabrics

A new major Operating Light that eliminates "third rail" hazard!

This is the *only* major Operating Light that eliminates the "spark" hazard . . . a constant source of danger to both patients and personnel. An exclusive Prometheus feature puts an end to this problem. This light assures adequate lighting at the bottom of the incision.

Rotary track mounted, there is never any need to move operating table to bring the light into proper position for the operation, whether it be an appendectomy, mastectomy, cholecystectomy, etc. Special scientific filters provide heatless, shadow-free, color-corrected light.



PROMETHEUS
ELECTRIC CORPORATION

Write for catalog of Prometheus Operating Lights, Sterilizers, Food Conveyors and other hospital equipment.

50 Webster Ave., New Rochelle, N. Y.

What's New . . .

Pharmaceuticals

Ilotycin

Ilotycin is a new orally administered antibiotic, effective against a wide variety of organisms and remarkably free of toxic effects. It is the result of a five year program of intensive research in the field. It does not destroy the colon bacillus in the intestinal tract and is not accompanied by allergic manifestations or gastro-intestinal side-effects. The product is effective when given by mouth. The manufacturer states that several months will elapse before the product is thoroughly investigated and considered ready for general distribution. **Eli Lilly & Co., Dept. MH, Indianapolis 6, Ind. (Key No. 359)**

NTZ Nasal Solution

NTZ is a new double-acting antihistaminic-decongestant developed to relieve the distressing head symptoms of the common cold which may be due to both a virus and to an allergic reaction. The product may be applied by droplet instillation, nebulizer or tampon and is supplied in bottles of 30 cc. with dropper. **Winthrop-Stearns Inc., Dept. MH, 1450 Broadway, New York 18. (Key No. 360)**

Armazide

Armazide is the Armour brand of Isoniazid or isonicotinic acid hydrazide, intended for use in the treatment of tuberculosis. The product is still under careful scrutiny to determine its exact place in the therapy of tuberculosis and is currently reserved for patients who have become resistant to streptomycin. Patients under Armazide therapy must be under close medical supervision as there are several contra-indications and cautions to be observed in its use. It is offered in the form of 50 milligram tablets, 100 to the bottle, for oral administration. **Armour Laboratories, Dept. MH, 520 N. Michigan Ave., Chicago 11. (Key No. 361)**

Redisol Elixir

Redisol Elixir is a new dosage form of vitamin B_{12} for stimulation of appetite. The product is readily miscible and therefore an excellent vehicle for prescription with a variety of drugs. The addition of buffering agents assures greater stability. It has been indicated as of value as a nutritional factor. It is a cherry-flavored elixir which is highly palatable and therefore easy to administer to children with sluggish food habits. Redisol is already on the market in tablet form. **Sharp & Dohme Inc., Dept. MH, 640 N. Broad St., Philadelphia 1, Pa. (Key No. 362)**

Mol-Iron E.M.F.

White's Mol-Iron E.M.F. is a new addition to the Mol-Iron family. It is indicated for the management of iron deficiency anemia, many macrocytic anemias, and as an adjunct to specific therapy in the treatment of pernicious anemia where regression of the "relapse" stage has been accomplished. It contains ferrous sulfate, molybdenum oxide, vitamin B_{12} activity equivalent, gastric substance, folic acid, ascorbic acid and desiccated liver and is supplied in bottles of 100 small, hard-shelled capsules. **White Laboratories, Inc., Dept. MH, Kenilworth, N. J. (Key No. 363)**

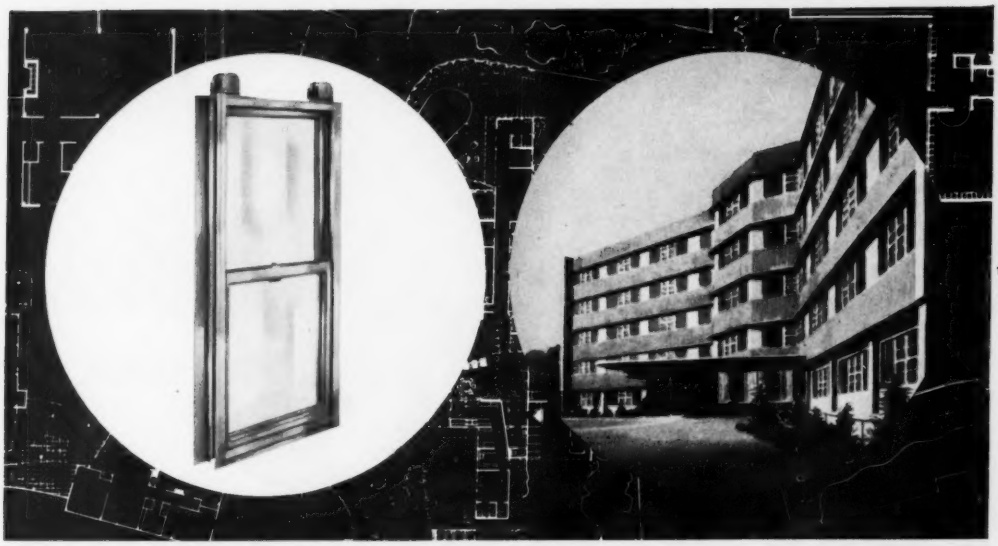
Isolyn

Isolyn is the Abbott name for isonicotinic acid hydrazide grooved tablets. It is recommended as an adjunct to treatment of streptomycin-resistant tuberculosis or tuberculosis not responding to previous therapy. It is supplied in bottles of 100 and 1000. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 364)**

(Continued on page 274)

made to outlast

...any hospital



Ceco-Sterling **Double-Hung**
Aluminum Window, series 200-B

In times like these it's just good business to take a second long look when selecting windows for your hospital buildings. • Cost of course is a factor, but the WAY cost is figured is the important thing. • How long will the windows last? What about maintenance? Those two questions are keys to better buying and here Ceco-Sterling Aluminum Double-Hung Windows win on both counts. • You can be sure they will outlast any hospital building. Engineered with exacting care, and made of ageless aluminum, they give rugged lifetime service . . . won't rust, rot, warp, or swell. They resist climatic change . . . provide the tightest weather seal ever. • When it comes to maintenance Ceco-Sterling Aluminum Windows deliver a plus value. No painting is necessary and cleaning is a mere matter of wiping. There are other advantages too, such as easy installation . . . simplified anchorage . . . smart styling . . . with a look of the future. • We like to sum it all up this way . . . when you use Ceco-Sterling Aluminum Windows you know you use the very best, you're sure of savings too.

Ceco Steel Products Corporation • General Offices: 5601 W. 26th St., Chicago 50, Illinois • Offices, warehouses and fabricating plants in principal cities

In construction products **CECO ENGINEERING** *makes the big difference*

Keep Food Service Costs Down

with

DIXIE CUPS

. . . the paper cups everyone knows by name!

Combating today's skyrocketing costs is easier when you use Dixie Cups. World-famous Dixie Cups and food containers lower operating expenses . . . save you in *three* vital ways:

TIME . . . Always ready for instant-use, Dixie Cups are designed for quick, easy handling. Trays are lighter . . . trips back to the kitchen fewer!

LABOR . . . Dixie Cups mean less dishwashing . . . less sterilizing . . . less stacking. *And*, you cut down on costly, profit-eating glass breakage with genuine Dixie Cups!

FOOD . . . Dixies' wide variety of shapes and sizes assure accurate portion control . . . cuts food waste. Tight-fitting Dixie lids hold flavor in . . . protect food until served!

Yes, sanitary, sturdy, famous-name Dixie Cups and Food Containers go a long way toward keeping food service costs down! Isn't it time you switched to Dixie Cups?

DIXIE CUP COMPANY

EASTON, PENNA. · FT. SMITH, ARK. · CHICAGO, ILLINOIS · ANAHEIM, CALIF. · DARLINGTON, S. C. · BRAMPTON, CANADA

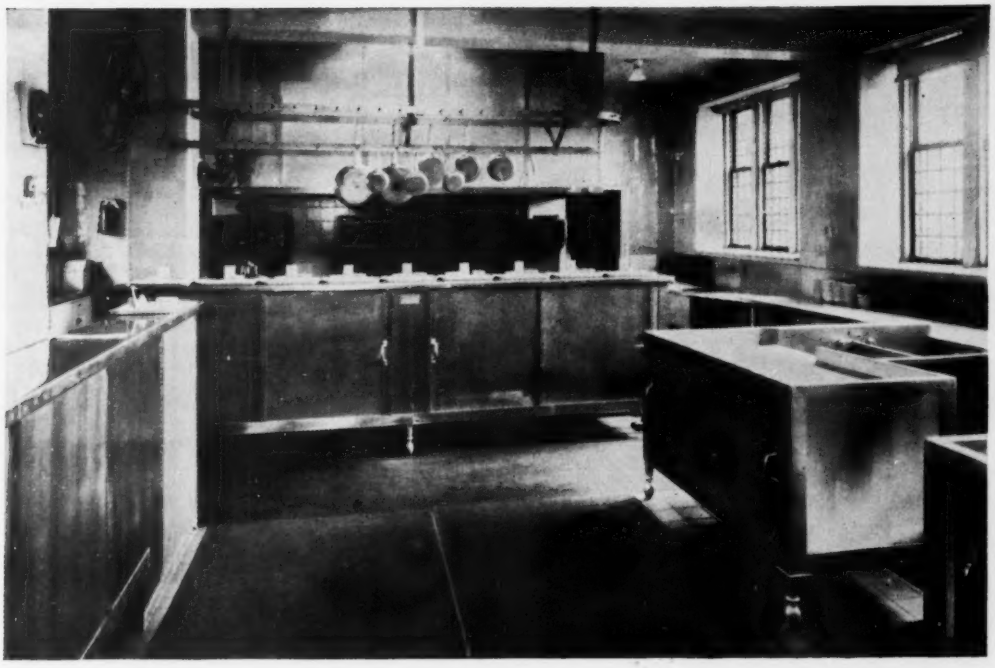
COLD DRINK DIXIE CUPS for fruit and vegetable juices.

COLD DRINK DIXIE CUPS for milk and soft drinks.

HOT DRINK DIXIE CUPS for coffee, tea, cocoa.

PAC-KUP FOOD CONTAINERS for soups, stews, main dishes.

DIXIE DESSERT DISHES for ice cream, stewed fruits and puddings.



ENDURO is an Old-Timer in Home for the Aged

● Although you'd never guess its age from its appearance, this ENDURO Stainless Steel kitchen was installed 'way back in 1927. Today, it still is bright, clean, sanitary and efficient. Despite unusually corrosive water conditions, the equipment has required no maintenance other than routine cleaning. From all indications, it could continue to give 'round-the-clock service for another quarter-century.

How can it last so long? ENDURO simply refuses to break down or wear out in hard daily usage. It resists rust and corrosion, resists abrasion and wear. It is easy to clean and to keep clean without hard scrubbing.

Through its long useful life, ENDURO helps administrators of endowed institutions maintain high service standards on fixed dollar incomes . . . and, in the face of rising costs. Once ENDURO food serving and preparation equipment is installed, there's no new capital periodically required for replacement . . . no expense for refinishing or painting. Cleaning costs are low.

This same type of ENDURO Stainless Steel—a straight-chromium analysis—which has performed so capably in this home for the aged is available to you today. Ask your equipment supplier about it, or write:

REPUBLIC STEEL CORPORATION

Alloy Steel Division • Massillon, Ohio

GENERAL OFFICES • CLEVELAND 1, OHIO

Export Department: Chrysler Building, New York 17, N. Y.

See and Hear
"THE STORY OF STAINLESS"

Full-color, 16 mm sound film —27 minutes running time. Dramatic . . . historic . . . interesting. Available to qualified groups without charge. Requires 16 mm sound projector. Send name of organization, type of projector, requested date to Ideal Pictures Corp., 65 E. So. Water St., Chicago 1, Ill., or write Republic Steel, Dept. K, Cleveland 1, Ohio.

Republic

REPUBLIC STEEL

ENDURO STAINLESS STEEL

Other Republic Products include Carbon and Alloy Steels—Pipe, Sheets, Tubing, Lockers, Shelving, and Fabricated Steel Building Products

What's New . . .

Parenteral and Topical Bacitracin

Bacitracin for parenteral use and sterile bacitracin powder for topical use are now available. Both dosage forms of the antibiotic are being supplied in vials containing 50,000 units each. Bacitracin has a therapeutic spectrum closely resembling that of penicillin but has been found to combat infections caused by organisms resistant to penicillin therapy. **Chas. Pfizer & Co., Inc., Dept. MH, 630 Flushing Ave., Brooklyn 6, N. Y. (Key No. 365)**

Phenergan

Phenergan is being made available in several new forms. Phenergan Lotion with Neocalamine is a pleasant, soothing lotion designed to stop the itching in many skin disorders. It has the soothing, cooling and mild astringent action of neocalamine lotion. Cream Phenergan Hydrochloride is a disappearing cream containing ethyl phenothiazine hydrochloride also designed to control itching. Phenergan Expectorant with Codeine is indicated for cough associated with the common cold, minor infections of the upper respiratory tract or minor throat irritations. **Wyeth Incorporated, Dept. MH, 1600 Arch St., Philadelphia 3, Pa. (Key No. 366)**

Hydrolose Fortified

Hydrolose Fortified is a new bulk-producing preparation for the relief of constipation. Containing laxatives in addition to its bulk-producing agent, the product causes positive but gentle action within eight to twelve hours after administration. It is supplied as a palatable syrup in 12 fluid ounce bottles. **The Upjohn Co., Dept. MH, Kalamazoo, Mich. (Key No. 367)**

Neobacin

Neobacin is a new antibiotic combination producing an unusually high cure rate in amebiasis, infectious diarrhea of infants and children, and in the specific dysenteries. The combination consists of neomycin and bacitracin, both of which exert their actions within the intestinal tract. Neither is absorbed into the blood stream to any appreciable extent. The product is available in tablet form.

Neobacin is also available in ointment form. Containing the same antibiotic combination, it has proved effective for the prevention of infections in minor cuts, wounds, burns and abrasions. **C. S. C. Pharmaceuticals, Division of Commercial Solvents Corp., Dept. MH, 260 Madison Ave., New York 16. (Key No. 368)**

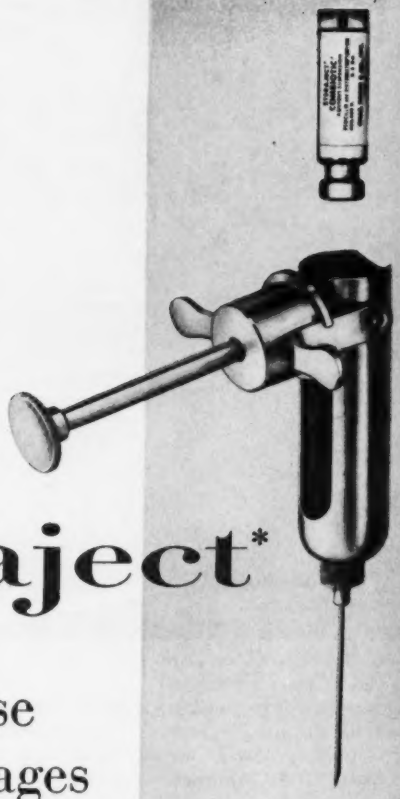
(Continued on page 278)

Product Literature

• An 18 minute **film on how a modern laundry plant processes 110,000 pieces of linen in an eight hour day** is available from Troy Laundry Machinery Division, American Machine and Metals, Inc., East Moline, Ill. Featuring the new million dollar centralized laundry of the Union Pacific Railroad system, the sound motion picture is available for showing to groups of hospital executives and to laundry and linen supply officials. **(Key No. 369)**

• **The Kewanee Round "R" Boiler** for oil, gas or stoker firing is described and illustrated in the new **Catalog No. 92** released by Kewanee-Ross Corp., Kewanee, Ill. Complete information on the quality features of the boiler are given as well as detailed listing of ratings, dimensions, equipment and trims. **(Key No. 370)**

• Complete equipment for the laboratory department of various sized hospitals, showing the quantity needed and the cost of each item, is listed in the new booklet, **"Suggested Lists of Equipment and Supplies for the Laboratory Department of 50, 100 and 200 Bed General Hospitals,"** issued by Central Scientific Co., 1700 Irving Park Rd., Chicago 13. **(Key No. 371)**



only

Steraject*

offers

all these

advantages

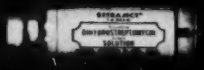
- ***widest selection*** of antibiotic disposable cartridges. Two cartridge sizes for one unique syringe.
- ***no waste*** from use of multiple dose vials. Ends costly syringe breakage.
- ***saves time*** on the floor...no reconstitution required. Cartridges are individually labeled, simple to store.

For further details see your Pfizer Professional Service Representative.

Steraject Penicillin G Procaine Crystalline in Aqueous Suspension (300,000 units)

Steraject Penicillin G Procaine Crystalline in Aqueous Suspension (1,000,000 units)

Steraject Combiotic* Aqueous Suspension (400,000 units Penicillin G Procaine Crystalline, 0.5 Gm. Dihydrostreptomycin)



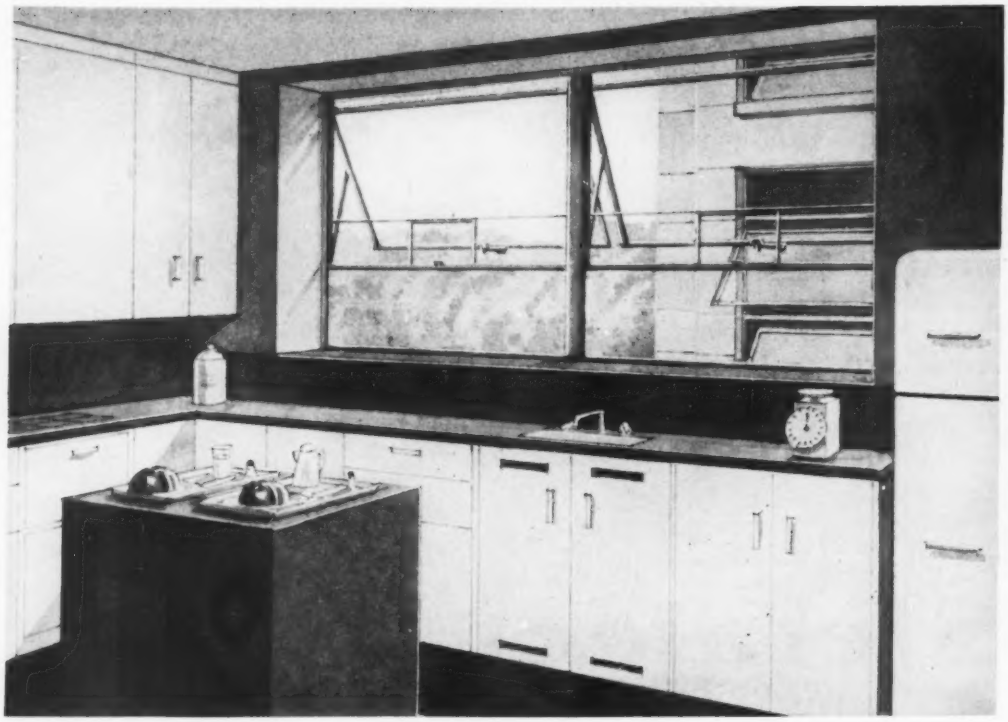
Steraject Dihydrostreptomycin Sulfate Solution (1 gram)

Steraject Streptomycin Sulfate Solution (1 gram)

introduced by **Pfizer** *world's largest producers of antibiotics*

ANTIBIOTIC DIVISION, CHAS. PFIZER & CO., INC., BROOKLYN 6, N. Y.

*TRADEMARK, CHAS. PFIZER & CO., INC.



Make the work of preparing hospital meals more pleasant — in surroundings flooded with daylight and adequately ventilated — as in this Diet Kitchen with its Lupton "Master" Aluminum Windows.

Slim lines give them eye-appeal, let in maximum daylight per window opening — yet there is no sacrifice in strength. Frames and ventilators are made of aluminum alloy, extruded in shapes especially designed for windows — to insure sturdiness.

Projected-type ventilators shield openings and provide good ventilation in all weather. Continuous, overlapping contact inside and outside assure minimum air infiltration. Ventilators will always close snug and tight, open easily. Here is the secret of their unusually low maintenance costs — Lupton "Master" Aluminum Windows will never need painting.

Available from coast to coast, Lupton "Master" Aluminum Windows fully meet the A.W.M.A. specifications for Series PA-2 quality approved projected windows for commercial and monumental buildings. For complete details get in touch with your local Lupton Representative or write us.

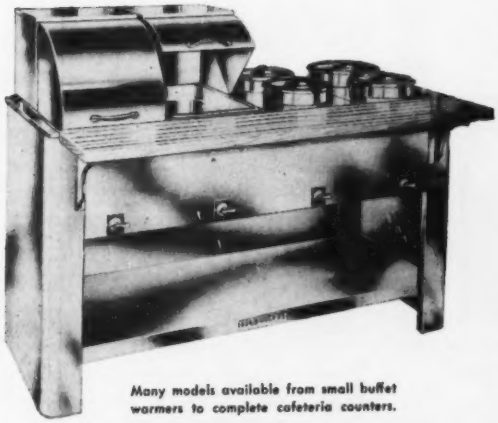
MICHAEL FLYNN MANUFACTURING COMPANY
700 East Godfrey Avenue, Philadelphia 24, Penna.
Members of the Metal Window Institute and Aluminum Window Manufacturer's Association

LUPTON
METAL WINDOWS

See the THURMADUKE exhibit—National Hotel Show—Grand Central Palace, New York City, November 10-14, Booth H, Gas Exhibit, Main Floor, 47th Street entrance.

IS THURMADUKE EQUIPPED

TO PROVIDE THE FINEST FOOD WARMING AFLOAT



Many models available from small buffet warmers to complete cafeteria counters.

For complete specifications, Write us for Catalog MH-10.

For several reasons, important to every buyer of food warming equipment, we are proud to announce the installation of **Thurmaduke Waterless Food Warmers** on the new, record-breaking liner, United States Line's Flagship, *S. S. United States.*

(1) Because food service at sea presents greater problems than the average operation ashore, no effort is spared to select the food warmer providing the utmost efficiency in keeping foods palatable.

(2) Such equipment must withstand rougher than usual treatment because of the vibration and stresses present in the ship itself, while at sea. This requires exceptionally rugged, welded construction.

(3) The very selection of equipment to meet these rigid requirements is placed in the hands of unusually competent staffs whose experience in the field lends increased importance to their selections.

We can think of no sounder reasons to recommend that you call your local Thurmaduke Dealer before you buy any food warmer. He can explain in a few minutes how Thurmaduke can do the same outstanding job for you . . . at a saving.

DUKE MANUFACTURING CO.
ST. LOUIS 6, MO.

What's New . . .

• How sunrooms, breezeways and other similar areas can be open to light and air and completely closed for protection in bad weather is shown in a new folder on **"Porch Enclosures"** issued by Ludman Corporation, P. O. Box 4541, Miami, Florida. The folder shows uses of Ludman Windo-Tite Jalousies for attractive appearance and practical comfort in any weather. **(Key No. 372)**

• The Aatell and Jones **Holiday Tray Appointment Club** has been developed to permit hospitals and other institutions to buy tray items, such as place mats, doilies, napkins and similar items, either for individual holidays, in various holiday groups or for a year's holiday requirements. With this system hospitals can plan ahead, thus saving time and assuring having the items on hand when the holiday approaches. Shipping costs are also reduced for the group packaged shipments. The idea has been developed by Aatell and Jones, Dept. MH, 3360 Frankford Ave., Philadelphia 34, Pa. **(Key No. 373)**

• **"Modern Sanitation Practices"** is the title of a brochure on sanitation procedures in institutions released by Klenzade Products, Inc., Beloit, Wis. The maintenance products information is supplemented with illustrations, charts and diagrams. **(Key No. 374)**

• **Catalog No. 433** gives detailed information on **"Mitchell Commercial Fluorescent Lighting"** for schools, hospitals, offices, and other institutions and commercial buildings. Published by Mitchell Mfg. Co., 2525 N. Clybourn Ave., Chicago 14, the catalog gives complete descriptive information on all models of Mitchell fluorescent lighting fixtures with illustrations and dimensional diagrams for each. **(Key No. 375)**

• The story of **Labelon "write on it" tape** is told in a new folder published by Labelon Tape Co., Inc., 450 Atlantic Ave., Rochester 9, N. Y. The pressure sensitive plastic tape for attaching to any smooth surface is resistant to dirt, oil, water and acids and is unaffected by temperature changes. Permanent marking on the tape can be done with a pencil, stylus or dry ball point pen. Data includes the colors and widths available, roll lengths and types of dispensers. **(Key No. 376)**

• The Story of **Puritan Floor Seals** is told in a new folder recently released by Puritan Chemical Co., 916 Ashby St., N. W., Atlanta, Ga. Each product described has an appropriate accompanying illustration. A how-to-do-it story on the back page illustrates and describes each step required to seal floors with these products. **(Key No. 377)**

• **Bulletin No. 125** describes the new **Barnstead Purity Meter,** an electronic testing device for determining the purity of either distilled or demineralized water. The instrument gives readings directly in parts-per-million. A conversion table shows the equivalent resistance and conductance. Issued by the Barnstead Still & Sterilizer Co., 124 Lanesville Terrace, Forest Hills, Boston 31, Mass., the bulletin has a section devoted to the Barnstead Conductivity Diverter. **Key. No. 378)**

• A new folder on Despatch Commander Ovens has been released by Despatch Oven Co., 619 S. E. 8th St., Minneapolis 14, Minn. Entitled **"Judge the Value Before You Buy," Bulletin No. 201** gives descriptive information and schedule of sizes and is illustrated by photographs of actual installations. **(Key No. 379)**

• Twenty-five years of experience in commercial refrigerator manufacturing are summed up in the new 50 page booklet, **"25 Years of Food Merchandising—The Tale of Tyler,"** released by Tyler Fixture Corporation, Niles, Mich. The booklet tells the story of food merchandising with text and illustrations and mentions use of Tyler equipment in hospitals and other institutions. **(Key No. 380)**

(Continued on page 280)

Architects and Engineers:
Magney, Tusler & Setter

University Advisory Architects:
Ray Jones and Winston Close

Pella VENETIAN BLINDS

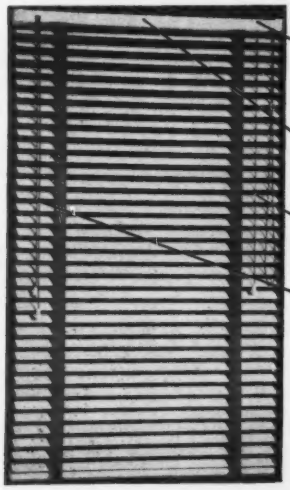
specified for

VARIETY CLUB HEART HOSPITAL

University of Minnesota, Minneapolis

171 Pella Venetian Blinds were specified for the Variety Club Heart Hospital, Minneapolis — only hospital in the United States for the study and treatment of heart conditions and the care of chronic heart patients. Pella Blinds are in keeping with the high type of efficiency throughout the hospital and perfectly adapted for hard day-in-day-out wear. Many quality features minimize maintenance problems, while giving properly regulated light and ventilation.

ALL THESE DECORATIVE AND MECHANICAL FEATURES FOR LASTING SERVICE AND LOW MAINTENANCE



EXTRA LARGE PULLEYS
Pella pulleys are one whole inch in diameter. Made of self-lubricating Lignum-vitae wood, they always roll smoothly. This feature reduces cord wear to absolute minimum.

10 YEAR GUARANTEE
Pella's neat metal headmember and the enclosed operating mechanism are guaranteed for 10 years against operating defects.

SEPARATE LOCKING CORD
Separate locking cord holds blind at any height, minimizes frictional wear on nylon operating cords.

SLIP-PROOF TILTING
Tilt cords never slip out of reach. Tilting mechanism of silent positive gear action outwears life of the blind.

NO JERKING OF CORDS
Pella's separate locking cord eliminates jerking of the operating cord from side to side to lock and unlock blind position. Another exclusive Pella feature.

Manufactured by THE ROLSCREEN COMPANY, PELLA, IOWA
Also Makers of Famous Pella Casement Windows and Rolscreens

ROLSCREEN COMPANY, Dept. D-47, Pella, Iowa

Please send me the free booklet on Pella Venetian Blinds in commercial and institutional buildings.
No obligation, of course

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What's New . . .

• **"Prove It"** is the title of a special booklet published by Remington Rand Inc., 315 Fourth Ave., New York 10, to help in meeting the overall accounting workloads for tax accounting. The brochure was prepared by tax specialists and points up several important time-saving steps. **(Key No. 381)**

• Two new booklets illustrating elevator door and entrance designs have been published by the Otis Elevator Company, 260 Eleventh Ave., New York 1. Eighteen basic decorative door designs, applied to both single-slide and center-opening or two-speed elevator doors are illustrated in **"Ornamental Designs." "Special Entrance Designs"** is the title of a folder showing 42 distinctive elevator entrance treatments. **(Key No. 382)**

• How nine kinds of maintenance work may be done on floors of all kinds, using Hild floor machines with interchangeable attachments, is illustrated and described in a folder recently released by Hild Foor Machine Co., 740 W. Washington Blvd., Chicago 6. The circular explains the operation of the **Hild Shower-feed Brush** for floor scrubbing and for shampooing rugs and tacked-down carpeting without removing it from the floor. **(Key No. 383)**

• The latest instruments and radiochemicals for radioisotope applications in the medical, education, industrial and research fields are discussed in a new two color **Condensed Catalog** issued by Nuclear Instrument & Chemical Corp., 223 W. Erie St., Chicago 10. **(Key No. 384)**

• Comprehensive information on the heavy duty synthetic detergent, **Arctic Syntex HD,** is given in a booklet published by the Technical Service Division of Colgate-Palmolive-Peet Co., 105 Hudson St., Jersey City 2, N. J. What Arctic Syntex HD is, how it is used for laundering and wet cleaning, with formulas for special washing problems, its use in rug and upholstery cleaning and special uses in automatic washers and for general cleaning are some of the subjects covered in this reference booklet. **(Key No. 385)**

• Three new booklets have been released by the Engineering Products Department of the RCA Victor Division, Radio Corporation of America, Camden, N. J. They cover features and applications of the **RCA 16 mm. sound film projects,** the **RCA 16 mm. magnetic recorder-projector** and a wide variety of **RCA sound products.** The brochure on the magnetic recorder-projector tells the story of magnetic striping of films for personalized sound recording in the 16 mm. field. A 20 page catalog describes in detail more than 50 items of equipment in the company's sound products line. A 12 page pamphlet gives details on the RCA "400" Senior and Junior 16 mm. sound film projectors and accessories. **(Key No. 386)**

• How the **Waste King Pulverator** disposes of garbage easily, safely, economically and in a sanitary manner, is discussed in a folder on the subject issued by Given Manufacturing Co., 3301 E. Fruitland, Los Angeles 58, Calif. The folder is illustrated by line drawings and operational diagrams which supplement the descriptive text. **(Key No. 387)**

• A new brochure on **Binfeed Stokers** has been issued by Canton Stoker Corp., Andrew Place S. W., Canton, Ohio. In addition to general data on the advantages of stokers, the brochure has three blue prints showing the front view, side view and floor plan of an ideal boiler room layout. **(Key No. 388)**

• **"Saunders Books for the Medical, Dental, Nursing and Allied Professions"** are listed in the 84 page 1952 Catalog issued by W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa. The catalog is fully indexed and carries illustrations. **(Key No. 389)**

THIS COUPON is provided for your convenience in requesting additional information.

- ☐ 319 Universal Overbed Frame
- ☐ 320 Orthopedic Composition
- ☐ 321 Elastic Hosiery for Men
- ☐ 322 Safety Sides
- ☐ 323 Conductive Foot Stool
- ☐ 324 Disposable Administration Set
- ☐ 325 Heat-Absorbing Glass
- ☐ 326 Bronchus Clamp
- ☐ 327 Surgiset, Jr.
- ☐ 328 Special Diet Foods
- ☐ 329 Bed-End Utility Table
- ☐ 330 Pediatric Proctological Table
- ☐ 331 Dictaphone Telecord System
- ☐ 332 Photo-Copy Machine
- ☐ 333 X-Ray Film Identification
- ☐ 334 Plastic Cleaner
- ☐ 335 Photo Paper Dispenser
- ☐ 336 Mobile Medicine Dispenser
- ☐ 337 Builders' Hardware
- ☐ 338 Portable Containers
- ☐ 339 Bulk Milk Dispenser
- ☐ 340 Sinus-Mastoid Positioning
- ☐ 341 Portion Scale
- ☐ 342 Folding Wheel Chair
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- ☐ 352 Automatic Ice Flaker
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- ☐ 354 Anti-Slip Floor Finish
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- ☐ 357 Rubber-Base Outdoor Paint
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- ☐ 360 NTZ Nasal Solution
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- ☐ 365 Parenteral Bacitracin
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- ☐ 367 Hydrolose Fortified
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- ☐ 369 Laundry Processing Film
- ☐ 370 Catalog No. 92
- ☐ 371 Laboratory Equipment
- ☐ 372 "Porch Enclosures"
- ☐ 373 Holiday Tray Club
- ☐ 374 "Modern Sanitation"
- ☐ 375 Catalog No. 433
- ☐ 376 Folder on Labelon Tape
- ☐ 377 Puritan Floor Scale
- ☐ 378 Bulletin 125
- ☐ 379 Despatch Commander Ovens
- ☐ 380 "Tale of Tyler"
- ☐ 381 "Prove It"
- ☐ 382 Elevator Booklets
- ☐ 383 "Hild Floor Machines"
- ☐ 384 Condensed Catalog
- ☐ 385 Arctic Syntex HD
- ☐ 386 Sound Film Booklets
- ☐ 387 Waste King Pulverator
- ☐ 388 "Binfeed Stokers"
- ☐ 389 Saunders Catalog

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MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc. 919 N. Michigan Ave., Chicago 11, Ill.

Supplier's News

Picker X-Ray Corporation, 25 S. Broadway, White Plains, N. Y., has been appointed sole and exclusive distributor of the **"Darex" Flexi-Cast Immobilizer** manufactured by **Dewey and Almy Chemical Co., Cambridge, Mass.** This new and interesting product was described in detail in **"What's New for Hospitals"** in the September issue of THE MODERN HOSPITAL, page 237.

Printed in U. S. A.

PREFERRED for COFFEE SERVICE

Hall China has all the qualities essential to good coffee service—a heavy, fireproof body that cannot absorb flavor or aroma; glaze that is pure, leadless and tasteless; thick walls that hold the heat. All Hall coffee pots are made by an exclusive process that inseparably fuses body, glaze, and color. Reasonable first cost and exceptional durability keep replacement at the lowest possible level.

Write on company letterhead for Catalog 48 which lists almost 1,000 different Hall China items and contains a color chart of the 26 beautiful underglaze colors that are available.

Hall Coffee Pots are available in sizes ranging from individual to banquet service.

THE HALL CHINA COMPANY • EAST LIVERPOOL, OHIO

The World's Largest Manufacturer of Fireproof Cooking China

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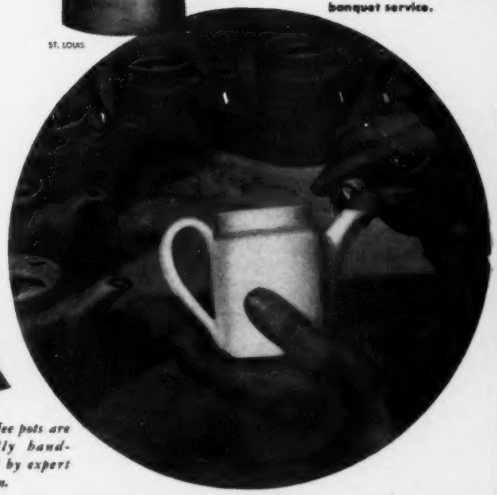

Hall coffee pots are carefully hand-finished by expert craftsmen.

. . . insures "never-miss" performance in your kitchen!

Just as actors stage a full dress rehearsal before facing an audience — we at Gumpert stage our own dress rehearsal for each of our products . . . to insure "never-miss" performance in your kitchen.

In our *Finished Product Proving Department* cooks working with equipment such as you use, take a sample of *each and every batch* as it comes from our production line and prepare it in ready-to-serve form.

FOR EXAMPLE: Gumpert's Gelatin Dessert is prepared according to the instructions on the can label. Then, the perfect brilliance of color . . . the absolute transparency . . . the pleasingly firm consistency . . . and most important of all the real fruit flavor which characterize this Gumpert product *must* be present in this sample — or the entire batch is rejected.

One of our Field Representatives will gladly demonstrate how you can benefit quality-wise and efficiency-wise — *at no greater real cost* — when you use Gumpert Food Specialties. Ask him today!

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. . . the choice of 40,000 customers — coast to coast!

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300 QUALITY FOOD SPECIALTIES FOR INSTITUTIONAL FEEDING . . . *and more on the way!*